State of California

State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA

July 26 - 27, 2007

BOARD AGENDA

and related material

Board Meeting, Thursday, July 26, 2007 at 8:00 a.m.
and continued at 4:30 p.m.
Friday, July 27, 2007 at 10:00 a.m.

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

MEDICAL BOARD OF CALIFORNIA – Executive Office
1434 Howe Avenue, Suite 92, Sacramento, CA 95825
(916) 263-2389 Fax (916) 263-2387 www.mbc.ca.gov

QUARTERLY BOARD MEETING

July 26 - 27, 2007

Embassy Suites
Tiburon/Sausalito Room
250 Gateway Boulevard
South San Francisco, CA 94080
(650) 589-3400

Action may be taken on any item listed on the agenda.

AGENDA

Thursday, July 26, 2007 – 8:00 a.m. to Noon
Thursday, July 26, 2007 – 4:30 p.m. – 6:30 p.m.

Friday, July 27, 2007 – 10:00 a.m.
(or at the conclusion of the Division meetings)

Thursday, April 26, 2007 8:00 a.m.

Open Session:

1. Call to Order/Roll Call
2. Introduction and Swearing in New Board Member

Closed Session:

3. Appointment of Executive Director (Pursuant to Government Code §11126(a))

Open Session:

4. Approval of Minutes from the April 26 - 27, 2007 Meeting
5. Legislation – Ms. Whitney
   - A. 2007 Legislation
   - B. 2007 Board Sponsored Legislation
     1. AB 253 – Board Restructure
     2. SB 761 – Diversion/Enforcement

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act.

6. President's Report – Dr. Fantozzi
   A. Communication from Interested Parties
   B. Executive Committee Report
   C. Committee Appointments

7. Executive Director's Report – Mr. Thornton
   A. Budget Overview and Staffing Update
   B. Meeting Survey and Rating Sheet
   C. Proposed Meeting Dates for 2008
   D. Federation of State Medical Board's (FSMB) Request to Distribute Pain Management Book to All Licensees
   E. Status Report – Board Notifications of Revocations, Suspensions and Meetings

7. Health Manpower Pilot Project Update – Dr. Gregg

8. California Physician Corps Program Update – Dr. Fantozzi/Ms. Yaroslavsky

9. Public Comment on Items not on the Agenda

Thursday, July 26, 2007 - Meeting continues at 4:30 p.m. or at the conclusion of the Diversion Committee Meeting

10. Strategic Planning – Ms. Kirchmeyer & Lewis Michaelson

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Friday, July 27, 2007 - Meeting continues at 10:00 a.m. or at the conclusion of the Division meetings.

11. Call to Order/Roll Call

12. Physician Humanitarian Award – Dr. Fantozzi

13. Reports from the Divisions/Committees
   A. Division of Licensing – Dr. Gregg
      Midwifery Committee – Ms. Chang
   B. Division of Medical Quality – Dr. Aristeiguieta
      Diversion Committee – Dr. Gregg

14. Cultural and Linguistic Physician Competency Workgroup
   A. Update on AB 1195 – Presentation by Institute for Medical Quality
   B. Update on AB 801 – Ms. Chang & Mr. Qualset

15. Wellness Update – Dr. Duruisseau & Dr. Norcross

16. Access to Care Committee Update – Mr. Alexander/Dr. Gitnick

17. Agenda Items for November 2007 Meeting

18. Public Comment on Items Not on the Agenda

19. Adjournment

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Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Open Meetings Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Board, but the President may apportion available time among those who wish to speak.

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For additional information call (916) 263-2389.

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Sacramento Convention Center
1400 "J" Street
Sacramento, CA 95814

April 26, 27, 2007

MINUTES

Agenda Item 1 Call to Order/Roll Call

Mr. Alexander called the meeting to order on April 26, 2007 at 4:05 p.m. A quorum was present and notice had been sent to interested parties.

Members Present:

Steve Alexander, President
Cesar Aristeiguieta, M.D.
James A. Bolton, Ph.D.
Hedy Chang
Shelton Duruisseau, Ph.D.
Richard D. Fantozzi, M.D.
Gary Gitnick, M.D.
Laurie C. Gregg, M.D.
Reginald Low, M.D.
Mary Lynn Moran, M.D.
Ronald L. Moy, M.D.
Janet Salomonson, M.D.
Ronald H. Wender, M.D.
Barbara Yaroslavsky
Frank V. Zerunyan

Members Absent:

Steven Corday, M.D.
John Chin, M.D.
Mitchell S. Karlan, M.D.
Dorene Dominguez

Staff Present:

David T. Thornton, Executive Director
Kimberly Kirchmeyer, Deputy Director
Kathi Burns, Manager, Licensing Unit
Candis Cohen, Public Information Officer
Janie Cordray, Research Specialist
Kurt Heppler, Staff Counsel, DCA Legal Office
Valerie Moore, Associate Analyst, Enforcement Program

Kelly Nelson, Legislative Analyst
Richard Prouty, Manager, Discipline & Staff Services Unit
Gary Qualset, Chief of Licensing
Regina Rao, Business Services
Paulette Romero, Associate Analyst
Teresa Schaeffer, Executive Assistant
Kevin Schunke, Regulation Coordinator
Anita Scuri, Senior Staff Counsel, DCA Legal Office
Renee Threadgill, Chief of Enforcement
Frank Valine, Diversion Program Administrator
Linda K. Whitney, Chief of Legislation
Curt Worden, Manager, Licensing Section

Members of the Audience:

Sandra Bressler, California Medical Association
Zennie Coughlin, Kaiser Permanente
Julie D'Angelo Fellmeth, Center for Public Interest Law
James Hay, M.D., California Medical Association
Saskia Kim, Senate Office of Research
Brett Michelin, California Medical Association
Carlos Ramirez, Office of the Attorney General

Agenda Item 2 Approval of Minutes from February 1 - 2, 2007 Meeting

It was M/S/C to approve the minutes from the February 1 - 2, 2007 meeting.

In order to remain consistent with the record, the agenda items presented in these minutes are listed in the order discussed at the April 26 - 27, 2007 meeting.

Agenda Item 3 President's Report

A. Communication from Interested Parties

Mr. Alexander disclosed he met with William Norcross, M.D., UCSD Medical School, to discuss his upcoming speaking engagement.

Staff is working on scheduling a meeting with the Attorney General's Office to discuss matters of mutual interest.

Mr. Alexander asked members to copy him, or in the future Dr. Fantozzi, on any communications with interested parties, and also alert the Executive Director.

B. Executive Committee Actions and Report

The Committee interviewed candidates for the Executive Director position at a meeting held on March 29, 2007 in Los Angeles, however, no action was taken or recommended at this time.

The issue of retention of enforcement staff remains a top priority. Mr. Thornton will provide further information on this issue under his report.

The Committee proposed Board members be more active in legislation in the future. Ms. Whitney will present the proposal to the full Board for review.

C. Media and Outreach Communications

The new Director of the Department of Consumer Affairs, Carrie Lopez, was invited to the meeting today to share her thoughts and perspectives with the Board.

D. Committee Appointments

Mr. Alexander indicated the newly appointed Board members may be receiving a letter from the Senate Rules Committee regarding their confirmation. The members were asked to send a copy of their response to Mr. Thornton for the Board's file.

It was announced the terms of Drs. Bolton, Corday, Gregg, Karlan and Moy and Ms. Yaroslavsky are expiring. If not reappointed, this would be their last meeting.

Agenda Item 4 Executive Director's Report

A. Budget Overview and Staffing Update

Mr. Thornton reported current board expenditures and revenue appear to be consistent with projections.

Stacie Berumen, a new manager in the Licensing Program, and Michael McCormick, a new analyst to oversee the midwifery program, were introduced.

Lynda Swenson, Area Supervisor for the Probation Unit, and Daryl Walker, Supervising Investigator II for Northern California area, were introduced. It was announced three new supervisors have been hired for the Northern California area.

B. Meeting Survey and Rating Sheet

The Board meeting evaluation form has been revised to incorporate the new meeting format. Members were asked to complete the form and provide any comments on any changes they would like to see made

to the meeting format or topics. A list of all the committees was distributed and members were asked to select the committees they are interested in joining.
Mr. Thornton announced the July 26, 27, 2007 quarterly Board meeting will be held at the Embassy Suites in South San Francisco.

C. Board Audits and RFP/Contracts

The Bureau of State Audits (BSA) has completed its review of the Diversion Program. The release date for the report is June 12, 2007. The BSA will overnight a copy of the report to all the members on June 11, 2007.

Ms. Kirchmeyer provided an update on the following board audits and contracts:

- The contract for the peer review study will be in place by July 1, 2007. The due date for completion of the study is July 31, 2008.
- The Fiscal audit will be performed by the BSA and should begin July 1, 2007.
- Staff is currently requesting a budget change proposal for funding to perform the full Board audit.
- The California Research Bureau has begun the review of the Board's public disclosure information and the laws outlining public disclosure.
- Staff is meeting with two individuals from the UC system on May 11, 2007, and will be working in conjunction with them to perform the medical malpractice study for funding of malpractice insurance for volunteer physicians.
- Staff is meeting with the Board of Registered Nurses (BRN) on May 7, 2007 to discuss the laser study.

D. Program Updates

Mr. Thornton reported staff has been working with the Department and is close to obtaining approval for reinstatement of the Medical Director position.

Mr. Thornton announced the first draft of the Vertical Enforcement Report will be mailed to the members for their review within the next few days. The members were urged to return their written comments to Ms.Threadgill by May 15, 2007.

Ms. Threadgill, Chief of Enforcement, was asked to provide some highlights of the report. She explained the report covers a selected timeframe in fiscal year 2003/2004 and calendar year 2006 as baselines, and includes a historic review of the number of changes already implemented, as well as some of the challenges and successes encountered during the period of the pilot.

E. Report on Recruitment and Retention of Investigators

Mr. Thornton summarized the efforts the Board has undertaken to address the recruitment and retention of Medical Board investigative staff. As reported in the past, the turnover of investigative personnel is a chronic problem the Medical Board has been trying to address dating back to 1990. He explained despite the legislative intent language added to SB 2375, which was recorded to say the pay scales for Medical Board investigators could be increased to within at least 5% of the pay scales for Special Agents of the Department of Justice, the pay scales were not increased to the level sought. This is due to the fact that Medical Board investigators keep getting tied to the Department of Consumer Affairs. It is his opinion that the investigators should be transferred to the Department of Justice.

The Board heard public comment from Julie D' Angelo Fellmeth, Center for Public Interest Law and former Medical Board Enforcement Monitor, in support of the transfer of investigators to the Department of Justice. She stated its been 18 years since this problem was addressed and its time it was resolved or at least meaningfully addressed.

Mr. Alexander took this opportunity to introduce the new Director of DCA, Carrie Lopez, and congratulated in her new position. Ms. Lopez thanked the members for their service and stated she looked forward to working with the board on resolving the retention issue.

Agenda Item 5 **Legislation**

The Board took the following positions on legislation:

AB 253 (Eng)	Restructuring of the Medical Board of California - **Sponsor/Support**
AB 329 (Nakanishi)	Chronic Diseases: Telemedicine - **Sponsor/Support**
AB 555 (Nakanishi)	Electronic Medical Records - **Support concept**
AB 1025 (Bass)	Professions: Denial of Licensure - **Neutral w/ amends**
AB 1073 (Nava)	Work. Comp.: CA Licensed Physicians on Utilization Review - **Support**
AB 1154 (Leno)	Diabetes: Pilot Program - **Watch and Assist**
AB 1224 (Hernandez)	Telemedicine: Optometrists - **Support**
AB 1276 (Karnette)	Prescription Containers: Labels with Purpose - **Support**
AB 1436 (Hernandez)	Scope of Practice: NPs and PA's - **Oppose**
AB 1444 (Emmerson)	Physical Therapists: Scope of Practice - **Oppose**
AB 1643 (Niello)	Supervision of NPs: More than Four - **Oppose unless Amended**
SB 102 (Migden)	Blood Transfusions: Brochure - **Support**
SB 472 (Corbett)	Prescription Drugs: Labeling Requirements and Panel - **Support**
SB 478 (Hollingsworth)	Physicians: Loan Repayment - **Watch**
SB 620 (Correa)	Anesthesia Permit for Physicians in Dental Offices - **Support**
SB 761 (Ridley-Thomas)	Diversion and Vertical Prosecution - **Sponsor/Support**
SB 764 (Migden)	MBC Reporting Licensee Information to OSHPD- **Support w/ Conditions**
SB 767 (Ridley-Thomas)	Drug Overdose Treatment: Liability - **Neutral**

SB 809 (Ashburn)	Expanding the Scope of Practice for NPs - **Oppose**
SB 907 (Calderon)	Compensation for Referrals - **Oppose**
SB 993 (Aanestad)	Psychologists: Scope of Practice: Prescribing - **Oppose**
SB 1048 (Comm. B,P&ED)	Healing Arts: Omnibus - **Support MBC Provisions**

The Board heard public comment from Steve Hartzell, Executive Officer, Physical Therapy Board of California, regarding AB 1444. Mr. Hartzell explained this is a two-year bill and urged the members to take a watch position on this bill at this time.

The Board heard public comment from Sandra Bressler and Dr. Jim Hay, California Medical Association, in opposition to the transfer of the investigators to the Attorney General's Office.

The last item Ms. Whitney discussed was the Executive Committee's request that staff develop a process in which Board members could be more proactive in the legislative process. Ms. Whitney directed the members' attention a copy of a memo provided in their board packet dated April 19, 2007 containing three options staff had developed.

Ms. Whitney recommended Option #3 - Establish two-person "expert committees" to work on subject matter issues with the legislative staff and provide advice to the Board. The members could meet with lawmakers and/or their staff at their district offices. It was also suggested that supervisors from the Board's district offices be assigned to go to legislative district offices to meet with staff and provide them with the information packet.

Dr. Gitnick thanked Ms. Whitney for being so responsive, however, he thought more should be done. He suggested the Board formulate their own legislative agendas or initiatives and proactively pursue those concerns in the interest of consumer protection. He proposed the President of the Board be charged with identifying agenda items that are important to the Board with regard to consumer protection and assign members to proactively meet with lawmakers in Sacramento to make it happen.

Mr. Alexander requested this issue be brought back to the Executive Committee for further discussion and consideration of the proposals presented.

Agenda Item 6 Federation of State Medical Boards

A. Update on 2007 Annual Meeting

Ms. Chang's report included the following:

- Dr. Bolton will be moderating a panel at the FSMB annual meeting to be held May 3 – 5, 2007 in San Francisco.
- Mr. Thornton and Mr. Alexander will be participating in a break-out presentation at this meeting.
- Ms. Chang thanked the members for their support in helping host a California reception at this meeting.

Agenda Item 7 Workgroup on Cultural and Linguistic Continuing Medical Education

Ms. Chang reported she attended a Continuing Medical Education (CME) provider workshop in April which was very informative. She will be meeting with CMA and IMQ on May 4, 2007, and will be attending another provider workshop on May 11. She reported the workgroup will hold a meeting in June.

Agenda Item 8 Strategic Planning Update

Ms. Kirchmeyer indicated the calendar for the Strategic Planning process needed to be changed due to the need to identify the top five priorities. Staff will meeting with Drs. Moy and Gitnick to develop the first draft plan and take it to the Executive Committee. Staff will be meeting with the facilitator, Mr. Michaelson to put together the performance measures and action plan for review by the members at the July board meeting. The final approval of the plan will be at the November Board meeting.

Agenda Item 9 Public Comment on Items not on the Agenda

There was no public comment. The meeting adjourned at 6:00 p.m.

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Friday, April 27, 2007

Agenda Item 10 Call to Order/Roll Call

Mr. Alexander called the meeting to order on April 27, 2007 at 9:35 a.m. A quorum was present and notice had been sent to interested parties.

Members Present:

Steve Alexander, President
Cesar Aristeiguieta, M.D.
James A. Bolton, Ph.D.
Hedy Chang
Shelton Duruisseau, Ph.D.
Richard D. Fantozzi, M.D.
Gary Gitnick, M.D.
Laurie C. Gregg, M.D.
Reginald Low, M.D.
Mary Lynn Moran, M.D.
Ronald L. Moy, M.D.
Janet Salomonson, M.D.

Ronald H. Wender, M.D.
Barbara Yaroslavsky
Frank V. Zerunyan

Members Absent:

Steven Corday, M.D.
John Chin, M.D.
Mitchell S. Karlan, M.D.
Dorene Dominguez

Agenda Item 11 Reports from the Divisions/Committees

Dr. Fantozzi reported the following:

- The Division of Licensing (DOL) deferred the Physician Assistant Committee (PAC) request for approval of a legislative proposal concerning the submission of regulations to a future meeting. Staff was directed to work with CMA to clarify the PAC and DOL responsibilities.
- The DOL deferred the PAC's request for approval of amended regulations and the setting of a hearing on "Delegation of Services Agreement". Staff was directed work with CMA to clarify the issue and set up a workgroup.
- The DOL appointed three members to the Special Faculty Permit Review Committee.
- The DOL appointed Dorene Dominguez to the Cultural and Linguistic Competency Workgroup.
- The Division held elections of officers for 2007/2008. The following were elected by acclamation:
  President – Laurie C. Gregg, M.D
  Vice President – Hedy Chang
  Secretary – Gary Gitnick, M.D.
- The Midwifery Advisory Council met and elected Faith Gibson, Chair and Dr. Ruth Haskins, Vice Chair. They are working on developing reporting data and statistics regarding the midwifery community.

Dr. Gregg reported the following:

- The Diversion Committee approved appointment of one new DEC member.
- The Diversion Committee appointed a seven person Diversion Advisory Council (DAC).
- The Diversion Committee referred the development and approval of guidelines for determining when a competency examination should be ordered for participants to the DAC.
- The Diversion Committee referred the establishment of consistent criteria for termination from the Diversion Program to the DAC
- The Diversion Committee referred the establishment of a mechanism for termination and revocation of license for continuously repeating participants to the DAC.

Dr. Aristeiguieta reported the following:

- The Division of Medical Quality (DMQ) approved appointment of a new DEC member, and seven Diversion Advisory Council members.
- The DMQ directed staff to find solutions to bring investigators and the attorney general's staff closer together to a workable vertical enforcement model.
- The Division held election of officers for 2007/2008 and approved the retention of the current leadership of the Division for continuity as follows:
  President - Cesar Aristeiguieta, M.D.
  Vice President - Barbara Yaroslavsky
  Secretary - Stephen Corday, M.D.
- The DMQ directed staff to look at the financial impact of increasing the expert reviewer's compensation and solicit additional applications for recruitment of expert reviewers.

Agenda Item 12 Health Manpower Pilot Project

Dr. Gregg provided an update on the proposed pilot project which would allow nurse practitioners, certified nurse midwives and physician assistants to perform early pregnancy termination and management of early pregnancy failures. She reported the proposed project remains with OSHPD and is pending approval or disapproval.

Agenda Item 13 California Physician Corps Program Update

Dr. Fantozzi reported there is currently $980,000 in the budget for awardees. Dr. Fantozzi indicated he is hopeful, with the support of the CMA, to be successful in finding financial funding to continue the program. If future funding is not found, the program could cease to exist.
Ms. Yaroslavksy reported she will be meeting with the Health Professions Education Foundation (HPEF) and members of OSHPD to review qualified applicants for the program. She thanked board staff for their continued support of this worthy program in providing improved access to healthcare in underserved areas in exchange for repayment of a physician's educational loans.

Agenda Item 14 Access to Care Committee Update

Dr. Gitnick reported the Committee met in Sacramento on April 26, 2007 and worked on developing its mission statement and heard a report from Dr. Fantozzi on the following: the Governor's Task Force on Diabetes Prevention and Management, Physician Workforce Roundtable, Best Practices Model, and the Telemedicine Program.

Agenda Item 15 Agenda Items for the July 2007 Meeting

Dr. Gregg suggested an update on the activities of the Physician Assistant Committee be a standing agenda item for the full Board.

Agenda Item 16 Election of Officers

Mr. Alexander asked for nominations for the Office of President. Dr. Gitnick nominated Richard Fantozzi, M.D. Dr. Fantozzi was elected President of the Medical Board by acclamation.

Mr. Alexander asked for nominations for the Office of Vice President. Dr. Fantozzi nominated Dr. Ron Moy. There being no other nominations, Dr. Moy was elected Vice President by acclamation.

Mr. Alexander asked for nomination for the Office of Secretary. Dr. Wender nominated Dr. Laurie Gregg. There being no other nominations, Dr. Gregg was elected Secretary by acclamation.

Agenda Item 17 Public Comment on Items Not on the Agenda

Jim Hay, M.D, California Medical Association, spoke in support of the continuing operation of the California Physician Corps Program.

Mr. Alexander offered a closing speech and thanked staff and the members for their confidence in his leadership during his presidency. He stated there had been five planned goals of his presidency:

- Raise awareness of MBC
- Look at the Board's restructuring
- Provoke a dialogue on medical errors
- Initiate meeting efficiencies
- Complete implementation of new enforcement model

In addition, there were three unplanned:

- Strategic Planning
- Access to care
- Dave's retirement and selection of a new Executive Director

He stated the Board had faced its challenges well, in restructuring, creating efficiencies, working on staff retention, initiating strategic planning. It is his hope that the Board will continue in team building with new members, and looks forward to the passage of AB 253 and its implementation.

He thanked Sandra Bressler and Julie D'Angelo Fellmeth for challenging him through his term, and for their candor and counsel.

He congratulated Dr. Fantozzi, and thanked him for his friendship and support during his presidency.

Dr. Fantozzi offered an acceptance speech and presented his agenda for the upcoming year. He stated California has a chance to be a leader in healthcare policy, and he would hope to lead the group in that role.

He announced the following committee assignments:

Executive Committee:	The membership includes the president, VP, secretary, division presidents, and immediate past president of the Board. In addition, he asked Ms. Yaroslavsky to create an outreach calendar for the members.
Diversion Committee:	Dr. Gregg, chair.
Physician Recognition Committee:	Dr. Moran, chair
Public Education:	Mr. Alexander, chair
Strategic Planning:	Drs. Moy and Gitnick, co-chairs
Midwifery Committee:	Ms. Chang
Access to Care:	Dr. Gitnick and Mr. Alexander, co-chair
Special Programs:	Dr. Wender, chair
International Medical Schools:	Dr. Salomonson, chair
Executive Director Search:	Dr. Wender to work with Dr. Fantozzi
Medical Errors:	Dr. Aristeiguieta, chair
Cultural & Linguistic Competency:	Ms.Chang, chair

In addition, he stated he would like the Board to help physicians that have no access to well-being committees. He assigned Shelton Duruisseau to work with CMA to develop an initiative to help these physicians.

Mr. Thornton reminded members to complete their meeting surveys and return them to Ms. Kirchmeyer.

Agenda Item 18 Adjournment

There being no further business the meeting adjourned at 10:30 a.m.

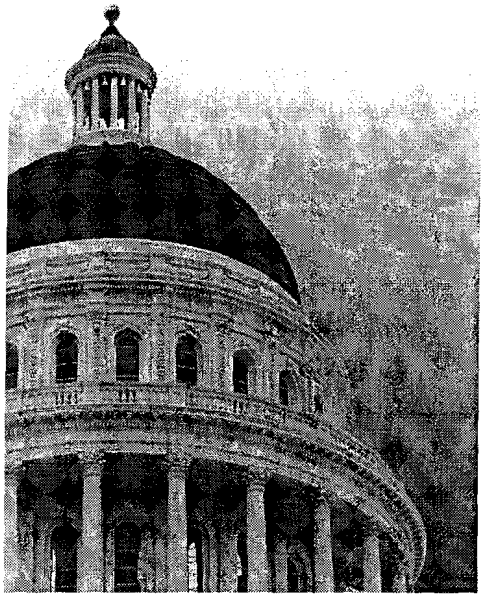
_____
Steve Alexander, President

_____
Richard Fantozzi, M.D., Vice President

_____
David T. Thornton, Executive Director

REFER TO YOUR LEGISLATIVE BINDER FOR DISCUSSION OF 2007 LEGISLATION

Sent under separate cover.



Medical Board of California's Physician Diversion Program

While Making Recent Improvements, Inconsistent Monitoring of Participants and Inadequate Oversight of Its Service Providers Continue to Hamper Its Ability to Protect the Public

June 2007 Report 2006-116

CALIFORNIA STATE AUDITOR

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June 7, 2007 2006-116

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning the Medical Board of California's Physician Diversion Program (diversion program).

This report concludes that although the diversion program has made many improvements since the release of the November 2005 report of an independent reviewer, known as the enforcement monitor, there are still some areas in which the program must improve in order to adequately protect the public. For instance, although case managers appear to be contacting participants on a regular basis and participants appear to be attending group meetings and completing the required amount of drug tests, the diversion program does not adequately ensure that it receives required monitoring reports from its participants' treatment providers and work-site monitors. In addition, although the diversion program has reduced the amount of time it takes to admit new participants into the program and begin drug testing, it does not always respond to potential relapses in a timely and adequate manner. Specifically, the diversion program has not always required a physician to immediately stop practicing medicine after testing positive for alcohol or a nonprescribed or prohibited drug.

Further, of the drug tests scheduled in June and October 2006, 26 percent were not performed as randomly scheduled. Additionally, the diversion program currently does not have an effective process for reconciling its scheduled drug tests with the actual drug tests performed and does not formally evaluate its collectors, group facilitators, and diversion evaluation committee members to determine whether they are meeting program standards. Finally, the medical board, which is charged with overseeing the diversion program, has not provided consistently effective oversight.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE
State Auditor

Medical Board of California's Physician Diversion Program

While Making Recent Improvements, Inconsistent Monitoring of Participants and Inadequate Oversight of Its Service Providers Continue to Hamper Its Ability to Protect the Public

June 2007 Report 2006-116

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Summary

Results in Brief

The Medical Board of California (medical board), a consumer protection agency with the goal of protecting the public by ensuring the initial and continued competence of the health care professionals under its jurisdiction, administers a program designed to rehabilitate physicians impaired by substance abuse or by mental health disorders. This program—the Physician Diversion Program (diversion program)—monitors participants' attendance at group meetings, facilitates random drug testing, and requires reports from work-site monitors and treatment providers. State law authorizes the diversion program and charges the medical board with its oversight and administration.

In addition to state employees who are principally responsible for the administration of the diversion program, other outside service providers, such as urine collection monitors (collectors) and group facilitators, participate in the monitoring and treatment of program participants. The program also uses seven regional diversion evaluation committees (DECs), made up of individuals with experience in the evaluation and management of persons impaired due to alcohol or drug abuse or a physical or mental illness, to determine prospective participants' appropriateness for and terms of participation in the program, as well as to make decisions on participants' successful completion of or termination from the program.

In our review of the diversion program, we focused on activities occurring after the November 2005 report was issued by an independent entity known as the enforcement monitor. Legislation passed in 2002 required that such an entity conduct a review of the medical board's enforcement and diversion programs. A November 2004 interim report issued by the enforcement monitor raised a number of concerns and made recommendations related to the diversion program. The November 2005 final report provided an update on these issues. We found that although the diversion program has made a number of improvements since the enforcement monitor's final report, it must continue to improve its performance and procedures in some specific areas to adequately protect the public.

The diversion program has established requirements designed to monitor participating physicians as they seek to overcome addictions and ailments that have the potential to impede their

Audit Highlights...

Our review of the Medical Board of California's (medical board) Physician Diversion Program (diversion program) revealed the following:

- *Case managers are contacting participants on a regular basis and participants appear to be attending group meetings and completing drug tests, as required.*
- *The diversion program does not adequately ensure that it receives required monitoring reports from its participants' treatment providers and work-site monitors.*
- *The diversion program has reduced the amount of time it takes to bring new participants into the program and begin drug testing, but the timeliness of testing falls short of its goal.*
- *The diversion program has not always required a physician to immediately stop practicing medicine after testing positive for alcohol or a nonprescribed or prohibited drug, thus putting the public's safety at risk.*
- *Twenty-six percent of drug tests in June and October 2006 were not performed as randomly scheduled.*

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- *The diversion program's current process for reconciling its scheduled drug tests with the actual drug tests performed needs to be improved.*
- *The diversion program has not been formally evaluating its collectors, group facilitators, and diversion evaluation committee members to determine how well they are meeting program standards.*
- *The medical board has not provided consistently effective oversight of the diversion program.*

ability to practice medicine. Our review found that although the diversion program is generally complying with some of these requirements, its compliance with other requirements falls short. Specifically, case managers appear to be contacting participants on a regular basis, as required, and participants generally appear to be attending group meetings and completing drug tests. However, the diversion program is not adequately ensuring that it receives required monitoring reports from participants' treatment providers and work-site monitors and receives all required meeting verification cards from participants. For example, for the sample of participants we reviewed, the diversion program should have obtained 51 reports from participants' therapists, but it obtained only 17 (33 percent). This low level of compliance may actually be an improvement over that achieved in the past, as indicated by the statistics obtained during the enforcement monitor's review. However, by not adequately ensuring that it receives required monitoring and treatment reports and meeting verification cards, the diversion program has less assurance that its participants are complying with their treatment plans and program requirements.

In addition to the monitoring requirements it has established, the diversion program has set goals related to the timeliness with which participants will be brought into the program. Of the three goals it has established for this purpose, the diversion program appears to be meeting two, and it has made substantial improvement in all three areas in recent years. Specifically, case managers, on average, are completing intake interviews with prospective participants within the goal of seven days from initial contact with the program, and participants are appearing before a DEC for final approval to join the program within the goal of 90 days from initial contact. Although the length of time from initial contact to first drug test decreased from an average of 35 days in 2003 and 2004 to an average of 18 days in 2005 and 2006 for the sample of participants we reviewed, the diversion program has not yet reached its goal of seven days for this activity.

In reviewing the diversion program's response to positive drug tests and other indications that a physician has relapsed into drug or alcohol abuse, we found that in some instances the program did not always respond in a timely manner and did not demonstrate that its actions were adequate, thus putting the public's safety at risk. Specifically, the diversion program has not always required a physician to immediately stop practicing medicine after testing positive for alcohol or a nonprescribed or prohibited drug, as required by program policy; has determined that positive drug tests were not a relapse without providing any justification for such a determination; and has not followed the advice of its advisory committee to have a trained medical review officer review contested results.

In addition, we found that the diversion program has generally not overseen its drug test system and its service providers in an adequate manner. Specifically, although it has shown improvement in this area in recent years, a large number of drug tests are still not being performed according to the randomly generated schedule. The most frequent reason given for drug tests not being completed as scheduled was that participants had requested vacations on those days. However, a significant portion of these vacation requests never received approval from appropriate program personnel. Other reasons drug tests were not completed as scheduled were that collectors moved the tests to other dates and participants did not show up to take the tests. In these instances, the program did not document the inadequate performance of collectors and did not ensure that collectors submitted an incident report for each missed test, as required by program policy.

Further, the diversion program's current process for reconciling its scheduled drug tests with the actual drug tests performed does not adequately or quickly identify missed drug tests or data inconsistencies between collectors' reports and lab results. We also found that although the diversion program relies heavily on its collectors, group facilitators, and DEC members in the monitoring and treatment of its participants, it has not been formally evaluating these individuals to determine how well they are meeting program standards.

For its part, the medical board has not provided consistently effective oversight of the diversion program. The medical board uses a committee made up of some of its members to oversee the program (diversion committee). However, the diversion committee's ability to oversee the program is hindered by a reporting process that does not give it a complete view of the program's performance and by a policy-making process that does not ensure that adopted policies are incorporated into the program's policy manual. Consequently, rather than discovering deficiencies through the reporting process and correcting them through a policy-making process that maintains some level of continuity, the diversion committee has been notified of program deficiencies in recent years by an outside entity—the enforcement monitor. Although improvements have been made, most of the enforcement monitor's recommendations have not yet been fully implemented, even though almost two years have elapsed since the publishing of the enforcement monitor's final report. Therefore, it does not appear that the diversion committee has made a diligent effort to ensure that the program promptly implements those recommendations with which it agreed.

Recommendations

To better monitor diversion program participants, program management should create mechanisms to ensure that group facilitators, therapists, and work-site monitors submit required reports, and that the participants submit required meeting verifications.

To ensure a timely and adequate response to positive drug tests or other indications of a relapse, the diversion program should do the following:

- Immediately remove practicing physicians from work when notified of a positive drug test.
- Require DECs to provide justification when they determine that a positive drug test does not constitute a relapse.
- Have a qualified medical review officer evaluate all disputed drug test results if its new advisory committee determines that this action is needed.

To provide adequate oversight of participants' random drug tests, the diversion program should ensure that both the case manager and group facilitator approve all vacation requests and should establish a more timely and effective reconciliation of scheduled drug tests to actual drug tests performed by comparing the calendar of randomly generated assigned dates to the lab results.

To ensure that it adequately oversees its collectors, group facilitators, and DEC members, the diversion program should formally evaluate the performance of these individuals annually.

To effectively oversee the diversion program, the medical board should require it to create a reporting process that allows the medical board to view each critical component of the program.

To ensure that it adequately oversees the diversion program, the medical board should have its diversion committee review and approve the program's policy manual. Thereafter, the diversion committee should ensure that any policy change it approves is added to the manual.

The medical board should ensure that areas of program improvement recommended by the enforcement monitor are completed within the next six months.

Agency Comments

The State and Consumer Services Agency agrees with our audit recommendations and has directed the Department of Consumer Affairs (department) to follow through with the medical board to ensure their implementation. The department also concurs with the recommendations and describes specific actions it would take to assist and encourage the medical board to ensure timely completion. The medical board agrees with each recommendation and describes a number of programmatic changes it has already implemented in response to the audit.

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Introduction

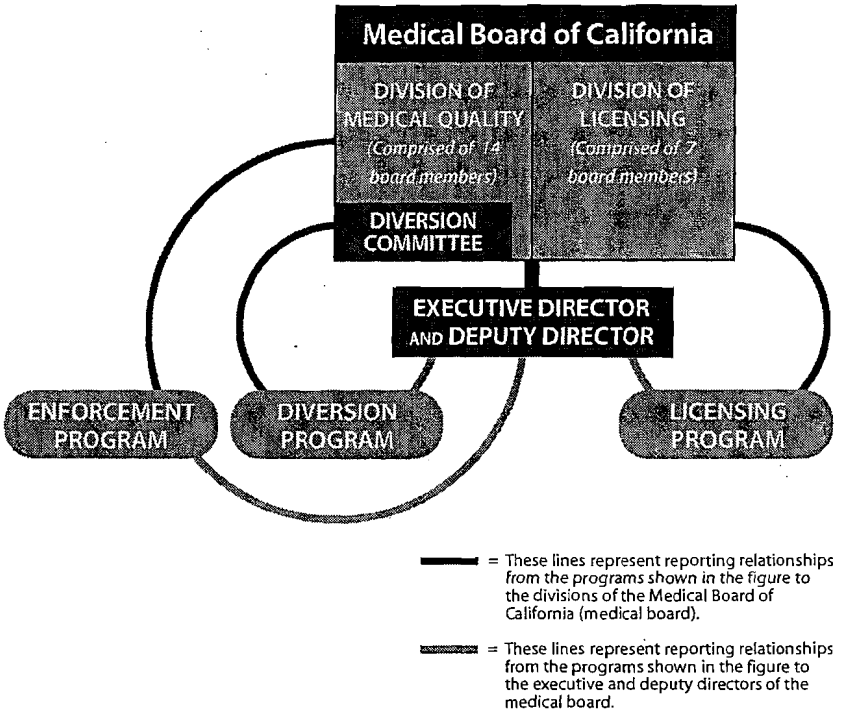
Background

The Medical Board of California (medical board) is a consumer protection agency with the goal of protecting the public by ensuring the initial and continued competence of the health care professionals under its jurisdiction. The medical board licenses physicians, surgeons, and other health professionals; investigates complaints against its licensees; and disciplines those found guilty of violating the law or regulations. In addition, the medical board administers a program designed to rehabilitate physicians impaired by substance abuse or by mental health disorders. This program—the Physician Diversion Program (diversion program)—monitors participants' attendance at group meetings, facilitates random drug testing, and requires reports from work-site monitors and treatment providers.

Medical Board

The medical board, which has 21 appointed members and is within the Department of Consumer Affairs, comprises two divisions—the Division of Licensing and the Division of Medical Quality—and employs an executive director and a deputy director to oversee the day-to-day operations of its programs, as indicated in Figure 1 on the following page. The Division of Licensing is responsible for approving medical education programs, administering physician and surgeon examinations, issuing licenses and certificates, and administering the medical board's continuing education and student loan programs. The Division of Medical Quality, through its enforcement program (enforcement), is responsible for investigating complaints against licensees of the medical board and disciplining those found guilty of violating the Medical Practice Act. The type of discipline the medical board administers depends on the nature of the violation and includes restrictions of medical duties, license suspension, license revocation, probation, and participation in the diversion program. As Figure 1 illustrates, the Division of Medical Quality has established a committee made up of some of its members (diversion committee) to directly oversee the diversion program.

Figure 1
The Structure of the Medical Board of California as It Relates to the Diversion Program



Source: The medical board's organizational chart for fiscal year 2006–07.

Diversion Program

Current state law authorizes the diversion program and charges the Division of Medical Quality with its oversight and administration. The intent of the legislation was that the medical board seek ways to identify and rehabilitate physicians and surgeons whose competency is impaired due to abuse of dangerous drugs or alcohol, or due to mental or physical illness, so that they may be treated and returned to the practice of medicine in a manner that will not endanger public health and safety. The medical board explained that the diversion program was started as a cost-effective alternative to the discipline process, which often takes years to complete, and that it better protects the public because it encourages physicians to seek assistance on their own, prior to the violation of any laws or professional codes and prior to the filing of any complaints. The medical board stated that this means a self-referring physician is being monitored and is seeking treatment one to two years earlier than if he or she had waited until disciplinary action was initiated. According to statistics provided in the medical board's annual

reports from the last seven fiscal years, the average number of participants in the program at the end of each fiscal year was just over 250, with a high of 273 in fiscal year 2000–01 and a low of 215 in fiscal year 2005–06.

When an individual enters the diversion program, he or she signs an agreement containing the specific provisions that must be followed while in the program.[1] The agreements vary by individual but generally include entrance into an inpatient treatment program for some length of time and, thereafter, attendance at two diversion group meetings and a minimum of three support group meetings, such as Alcoholics Anonymous or Narcotics Anonymous, each week; submission to at least four random drug tests each month; submission to work-site monitoring by a colleague; and an agreement to not practice medicine if requested and to remain in the program for five years. These requirements can be reduced after a period of time.

The requirements for physicians who enter the diversion program because of mental illness can vary somewhat, but generally follow the same pattern as those for participants who are dealing with substance abuse. For instance, participants with a mental illness receive drug tests and attend diversion group meetings alongside participants who have addictions to drugs and alcohol. The program administrator explained that, more often than not, participants with a mental illness have also had some form of drug or alcohol abuse in their past. For those who have not, the program does not want drug or alcohol use to interfere with their treatment and therefore prohibits the use of drugs or alcohol and conducts monitoring accordingly. Since fiscal year 2002–03 four participants per year, on average, have entered the diversion program primarily as the result of a mental illness.[2]

According to state law, successful completion of the program is to be determined by the program administrator and shall include, at a minimum, three years of sobriety and adoption of a lifestyle designed to maintain a state of mental health stability. According to statistics provided in the medical board's annual reports from the last seven fiscal years, the average number of participants leaving the program each year was 56. Of those, an average of 43 (77 percent) did so successfully.

[1] While an individual is being evaluated for entrance into the program, monitoring begins based on a standard interim agreement signed by the candidate, which is subsequently replaced by a formal diversion agreement after acceptance into the program.

[2] In 2002 state law was amended to permit enforcement to refer physicians diagnosed with mental illness into the diversion program. Although the state law included references to physicians with physical illnesses, the program administrator explained that the diversion program is not currently set up to assist physicians whose primary impairment is a physical illness.

Entry Into the Diversion Program

Physicians enter the diversion program in one of three ways. First, they may choose on their own to enter the program (self-referred). According to the medical board, these physicians often request entry at the urging of a hospital, colleague, or family member. Second, state law allows a physician to participate in the diversion program in lieu of potential discipline stemming from an investigation by enforcement, if the investigation is based primarily on mental illness or on the self-administration of alcohol or other drugs, and if there is no evidence of patient harm (board-referred). Participants diverted from the discipline process must sign a statement of understanding in which they agree that a violation would be a basis for discipline and could be prosecuted should the physician be terminated from the diversion program for failure to comply with program requirements. However, if a physician successfully completes the program, state law says that he or she shall not be subject to any disciplinary actions by the medical board for any alleged violation that resulted in the referral to the diversion program. The third way an individual may enter the diversion program is if the medical board directs the physician to participate in the program as part of a disciplinary order (board-ordered).

Pathways Into the Diversion Program

Self-referred—Participants can enter the program of their own volition.

Board-referred—Enforcement may refer physicians to the program instead of pursuing disciplinary action.

Board-ordered—The medical board may direct physicians to participate in the program as part of a disciplinary order.

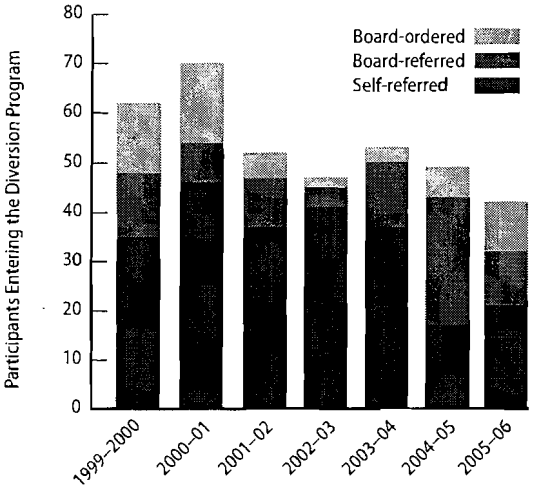
Source: March 2006 Physician Diversion Program informational pamphlet.

One of the key differences between board-ordered participants and those who are either self-referred or board-referred is that information related to self- or board-referred participants must be kept confidential from the public. Conversely, information on participants who have been ordered into the diversion program as part of a disciplinary action is a matter of public record.

According to statistics provided in the medical board's annual reports, the number of participants entering the program[3] in the last seven fiscal years averaged 54 each year, ranging from a high of 70 in fiscal year 2000–01 to a low of 42 in fiscal year 2005–06. As shown in Figure 2, the majority of participants entering the diversion program were self-referred in all the years except fiscal year 2004–05, in which board-referred participants outnumbered the other categories.

[3] The annual reports defined this term as being approved to enter the program and signing a formal diversion agreement.

Figure 2
Number and Type of Referral for Participants Entering the Physician Diversion Program During Fiscal Years 1999–2000 Through 2005–06



Source: Statistics provided in the medical board's annual reports.

In reference to the steep drop in self-referred participants in fiscal year 2004–05, the diversion program's administrator explained that, because of excessive caseloads in some regions, the program instituted a policy in fiscal year 2003–04 that delayed prospective participants' entry into the program. He stated that this practice grew in scope and impact until the policy was ended in the beginning of 2005. He indicated that this policy, as well as the fact that legislation had put a sunset date on the program and required a review by an outside entity, gave prospective participants and individuals within the treatment community the impression that the program was either not accepting new participants or would not be around to see participants through the recovery process. The program administrator explained that the program still has not fully recovered from this perception and said that he looks forward to the time when he can perform more extensive program outreach.

As to the sharp increase in board-referred participants in fiscal year 2004–05, the chief of enforcement explained that it was around this time that a statutory and policy change allowed enforcement to refer physicians affected by mental illness to the diversion program while continuing to complete an investigation into any quality-of-care issues. According to the chief, because this was new policy, enforcement may have referred some physicians affected by mental illness who it learned over time were not ideally suited for the diversion program. Thus, it reduced the number of these referrals in subsequent years. The chief also explained that a number of

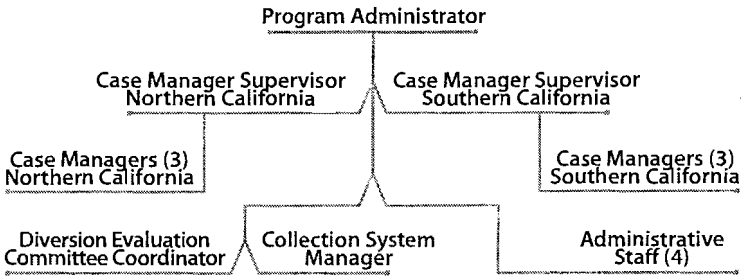
participants enter the diversion program as self-referred but then become board-referred after enforcement receives a complaint regarding them. She said that the diversion program's delayed entry policy quite possibly caused a number of participants to be classified as board-referred who might, without the delay in entry, have been classified as self-referred. The diversion program administrator agreed that this could be a plausible explanation for the increase in board referrals during fiscal year 2004–05.

Administrative Structure of the Diversion Program

In addition to state employees who are principally responsible for the administration of the diversion program (program staff), other outside service providers, such as urine collection monitors (collectors) and group facilitators, participate in the monitoring and treatment of program participants. However, although these service providers are paid directly by participants, program staff are responsible for screening the providers for competence. The program also uses seven regional diversion evaluation committees (DECs) to determine prospective participants' appropriateness for and terms of participation in the program, as well as to make decisions on participants' successful completion of or termination from the program. According to state law, each DEC is composed of five members who are appointed by the Division of Medical Quality and who have experience in the evaluation and management of persons impaired due to alcohol or drug abuse or a physical or mental illness.

As shown in Figure 3, the diversion program, which reported expenditures of approximately $1.1 million for fiscal year 2005–06, is staffed by 15 employees: a program administrator, two case manager supervisors, six case managers, a DEC coordinator, a collection system manager, and four administrative staff. Although the program administrator is ultimately responsible for carrying out program priorities, the day-to-day monitoring of participants' progress falls to the case managers. The diversion program has six case managers located in different regions of the State. A case manager is assigned to each participant based on his or her geographic location, and is responsible for monitoring the participant's compliance with his or her diversion agreement and coordinating information from all monitoring and treatment sources. The case manager is required to have one-on-one contact with each participant on a regular basis.

Figure 3
The Organizational Chart of the Diversion Program



Source: The medical board's organizational chart.

For each participant, the case manager leads a local case management team that includes the following key members:

- **An assigned DEC case consultant**—The DEC as a whole functions as an expert consultant for cases within its region. However, each participant is assigned one member of the DEC to act as a case consultant.

- **Group facilitator**—Each participant attends meetings conducted twice a week by a group facilitator who provides support for recovery and monitors program participants by observing them for any unusual behavior, tracking their attendance, and notifying the case manager of any issues or concerns. These individuals are selected and assigned by the program but are paid directly by the participants for their services.

- **Collectors**—Each participant is assigned a collector who is responsible for conducting observed urine collections and following the chain of custody protocol in submitting collections to the laboratory. The diversion program selects and assigns collectors. Participants pay collection costs and laboratory fees to their collector at the time of collection.

- **Work-site and hospital monitors**—Participants who are practicing must find, and obtain program approval for, a work-site monitor whose license with the medical board is valid and in good standing. Participants with hospital privileges must also have a hospital monitor. These individuals are responsible for observing the participant's condition while he or she practices medicine and submitting quarterly reports to the case manager.

Past Reports Involving the Diversion Program

In 1982 the Office of the Auditor General released the first in a series of audit reports on the diversion program titled *Review of the Board of Medical Quality Assurance,* followed by *The State's Diversion Programs Do Not Adequately Protect the Public From Health Professionals Who Suffer From Alcoholism or Drug Abuse* (1985), and *The Board of Medical Quality Assurance Has Made Progress in Improving Its Diversion Program: Some Problems Remain* (1986). In 2002 a bill was passed requiring the director of the Department of Consumer Affairs to appoint an independent "enforcement monitor" to evaluate the medical board's enforcement and diversion programs for a period not to exceed two years. The enforcement monitor was responsible for evaluating the effectiveness and efficiency of the medical board's diversion program and making recommendations regarding the continuation of the program and any changes or reforms required to ensure that physicians and surgeons participating in the program are appropriately monitored and the public is protected from physicians and surgeons who are impaired.

In both the auditor's and the enforcement monitor's reports, the findings and criticisms were similar, and included the following:

- The diversion program does not adequately monitor its assigned participants.
- Program monitors are not adequately trained and supervised.
- The diversion program does not terminate or notify enforcement regarding participants who have not complied with significant terms and conditions of their treatment plans.
- The medical board does not adequately supervise and review the program.

The enforcement monitor's initial and final reports, published in November 2004 and November 2005, respectively, raised additional issues and made specific recommendations that the medical board has recently made efforts to implement. We describe these issues and recommendations, and the medical board's responses, in greater detail in Chapter 3 and the Appendix.

Scope and Methodology

In response to the findings and recommendations from the study conducted by the enforcement monitor, the Joint Legislative Audit Committee requested the Bureau of State Audits to conduct

a review of the diversion program. Specifically, we were asked to review the program's effectiveness and efficiency in achieving its goals by evaluating the following:

- The timeliness of diversion services provided by the program.
- The thoroughness of the program's documentation of treatment services received by participants.
- The notification procedures when participants are terminated from the diversion program.
- The approval process and oversight of individuals providing services for the diversion program and the corrective action taken when these individuals fail to provide effective or timely services.
- The current administrative structure of the program.

To obtain an understanding of the diversion program, we reviewed associated laws and regulations. We also examined the program's policies and procedures and interviewed key personnel from the program and the medical board. To evaluate the timeliness of services provided by the diversion program and evaluate the monitoring of program participants, we reviewed the files of 40 randomly selected physicians who participated in the program between November 2005 and October 2006. We also obtained information on physicians participating in the diversion program during this time period from the program's Diversion Tracking System (DTS) and, in accordance with standards from the U.S. Government Accountability Office, obtained reasonable assurance that the data provided to us were complete. We conducted a preliminary assessment of using the DTS to perform analyses on all diversion program participants but determined that, for the purposes of this audit, reviewing the files of a sample of participants would be sufficient.

As shown in Table 1 on the following page, we randomly selected 10 physicians from the 83 who began their participation during our sample year—20 from the 206 physicians who participated in the program throughout the entire year and 10 from the 77 who ended their participation during the year we reviewed. Selecting our sample in this manner allowed us to review 11 percent of the overall population and at least 10 percent of each of the three categories shown in Table 1.

Our review of participant files included a number of elements, as indicated in the text box. In reviewing these elements, we took note of the thoroughness of the program's documentation—at times requesting additional documents from case managers and group

Table 1
Selection of a Sample of Physicians Who Participated in the Physician Diversion Program Between November 2005 and October 2006

	BEGAN PARTICIPATION DURING TIME PERIOD	PARTICIPATED DURING ENTIRE TIME PERIOD	ENDED PARTICIPATION DURING TIME PERIOD	TOTALS
Number of participants	83	206	77	366*
Random sample taken from group	10	20	10	40
Percentage of total	12%	10%	13%	11%

Source: Statistics provided from the Physician Diversion Program's Diversion Tracking System.

* The total includes all the participants who were in the program for any length of time between November 2005 and October 2006. This number differs from the statistics provided in the Introduction, which reported the total number of participants in the program at a given point in time.

facilitators so that we could complete our analysis. When evidence in the file, such as a positive drug test, indicated that a physician may have relapsed, we determined what steps the diversion program took in response. In some cases, the appropriate program response would have been to notify enforcement. In such instances, we determined whether the program did so.

In addition to our review of the monitoring of participants, we evaluated how the diversion program approves and oversees the collectors, group facilitators, and DEC members who assist with the program. As part of our review of the practices of collectors, we determined whether the randomly scheduled drug tests in June and October 2006 were completed as scheduled. If they were not, we attempted to ascertain the reasons why. We selected these two months because they were recent enough that information would still be readily available and because the July 2006 hiring of the current collection system manager fell between these two months.

Information Obtained in Our Review of a Sample of Diversion Program Participant Files

- From the initial phone contact, the length of time the diversion program took to complete the intake process, perform the first drug test, and have the participant meet with a DEC.
- The number of case manager contacts.
- The number of therapist and work-site monitor reports.
- The average number of diversion and other support group meetings attended.
- The average number of drug tests taken.
- The completion of an annual review by the DEC.
- The existence of any work restrictions.

Finally, we evaluated the current administrative structure of the diversion program by analyzing the cause of any shortcomings discovered during the audit procedures just described and determining whether the problems were caused or exacerbated by structural deficiencies within the program. Further, we evaluated the effectiveness of the reporting mechanisms used by the medical board to oversee the program, the level of oversight it has exercised over program policies, and the efforts the medical board has undertaken to respond to the enforcement monitor's reports.

Chapter 1

ALTHOUGH THE PHYSICIAN DIVERSION PROGRAM HAS SHOWN IMPROVEMENT IN SOME AREAS, ITS MONITORING OF PARTICIPANTS REMAINS INCONSISTENT

Chapter Summary

The Physician Diversion Program (diversion program) of the Medical Board of California (medical board) has established a number of requirements designed to monitor participating physicians as they seek to overcome addictions and ailments that have the potential to impede their ability to practice medicine. While the diversion program's compliance with these requirements is good in some areas, it is lacking in others. Specifically, case managers appear to be contacting participants on a regular basis, as required, and participants generally appear to be attending group meetings and completing drug tests. However, the diversion program is not adequately ensuring that it receives required monitoring reports from participants' treatment providers and work-site monitors. Despite this lack of assurance that participants are meeting treatment requirements and not demonstrating signs of relapse at work, the diversion program has in some instances granted physicians reductions in the required number of group meetings or in the work restrictions originally placed on them.

In addition to the monitoring requirements it has established, the diversion program has set goals related to the timeliness with which participants are to be brought into the program. Of the three goals it has established for this purpose, the diversion program appears to be meeting two, and it has made substantial improvement in all three areas in recent years. Specifically, case managers, on average, are completing intake interviews with prospective participants within the goal of seven days from initial contact with the program, and participants are appearing before a diversion evaluation committee (DEC) for final approval to join the program within the goal of 90 days from initial contact. With respect to its goal of conducting the first drug test within seven days of the initial contact, we found that the diversion program has decreased its average time from 35 days in 2003 and 2004 to 18 days in 2005 and 2006 for the sample of participants we reviewed; however, it still is not meeting its goal of seven days.

In reviewing the diversion program's response to positive drug tests and other indications of a relapse, we found that in some instances the program did not respond in a timely manner and did not demonstrate that its actions were adequate, thus putting the public's safety at risk. Specifically, the diversion program has not always required a physician to immediately stop practicing medicine after testing positive for

alcohol or a nonprescribed or prohibited drug, as required by program policy; has determined that positive drug tests were not a relapse without providing any justification for such a determination; and has not followed the advice of its advisory committee to have a trained medical review officer examine contested results.

The Quality of the Diversion Program's Monitoring of its Participants Varies

Overall, diversion program case managers appear to be contacting participants on a regular basis, and participants generally appear to be attending group meetings and completing drug tests as required. In contrast, case managers and program management are not adequately ensuring that the program receives reports for participants that would, among other things, provide evidence that participants are going to group meetings and individual therapy when required, and are not exhibiting signs of substance abuse in the workplace. However, despite not receiving all of their required reports, the diversion program granted some physicians reductions in the required number of diversion group meetings or in the work restrictions originally placed on them.

To determine how well the diversion program monitors its participants and how compliant participants are with program requirements, we reviewed a random sample of 40 physicians who participated in the diversion program for some amount of time between November 2005 and October 2006.[4] In summarizing the data from the various functional areas of compliance, we found that the overall levels of program compliance fell within three distinct groups—good, fair, and poor. As indicated in Table 2, it was in the receipt of required reports that the program and its participants underperformed.

Case Managers Are Generally Contacting Participants on a Regular Basis

Diversion program policies require case managers to have regular in-person or telephone contact with their assigned program participants. The program administrator explained that the general expectation is that case managers have monthly contact with participants. For the 40 participants we reviewed, we determined that to meet this expectation overall, case managers would have needed to have 342 contacts with these participants during the time period November 2005 to October 2006. In total, they made 334 contacts, nearly all of the expected number.[5]

[4] Three of the 40 randomly selected participants reside outside of California and were thus considered out-of-state participants. The program requirements for these individuals are somewhat different from those for their in-state counterparts.

[5] The length of time each participant was in the program varied. The expected number of case manager contacts is based on the number of full months the participants in our sample were in the program.

Table 2
The Overall Level of Compliance for a Sample of Diversion Program Participants

CATEGORY OF COMPLIANCE	LEVEL OF COMPLIANCE*
Case manager contacts	Good
The following reports were received as required:	
Diversion group attendance reports	Fair
Therapist reports	Poor
Work-site monitor reports	Fair
Verification of support group attendance	Poor
The levels of attendance at the following meetings or events:	
Diversion group	Good
Support group	Good
Drug tests	Good

Source: Auditor analysis of information obtained from a sample of participant files at the Physician Diversion Program.

* Good (above 80 percent), Fair (60 percent to 80 percent), Poor (below 60 percent).

While this overall level of performance is good, some participants received more contacts from their case managers than required, while a relative few received significantly less. In particular, four participants received three to six fewer contacts than the expected number. When we asked about the reason for this deficiency, we found that there were eight months in which all four were assigned to the only case manager supervisor at the time and a program employee who was not yet trained as a case manager. The employee who was assisting the case manager supervisor explained that they were primarily performing the "paperwork duties" on these participants during that time and that participant contact consisted of handling participants' problems over the telephone.

The case manager supervisor explained that this practice was used during a time when they did not have enough case managers to oversee the diversion program's caseload and said that, with the recent hiring of three case managers and a new case manager supervisor, she does not expect this to occur again.

The Diversion Program Is Not Ensuring That Required Monitoring Reports Are Submitted

In addition to regular contact from case managers, the diversion program monitors participants by requiring regular reports from group facilitators, therapists, and work-site monitors, and by requiring verification of support group attendance in some instances. However, based on our review, it appears that the diversion program

does not adequately ensure that these reports are received. The reasons provided for missing reports indicate that the program has not created mechanisms to ensure that program staff, and case managers in particular, have performed the duties required of them. In addition, it also appears that the diversion program does not carefully document changes to participants' program requirements by amending diversion agreements to reflect such changes. Consequently, the program has less assurance that its participants are in compliance with their diversion agreements and has less ability to hold participants and program personnel accountable for fulfilling program requirements.

The Level of Compliance for Diversion Group Attendance Reports Is Fair

Diversion program participants are required to attend one or two diversion group meetings a week. As we indicated earlier, they appear to substantially comply with this requirement. Without accounting for vacations and other approved absences, the participants we reviewed attended 92 percent of their required diversion group meetings. However, to calculate this percentage we had to contact a number of group facilitators to obtain attendance reports that had not been submitted to the program. In fact, of the 35 physicians for whom this requirement was applicable, the diversion program had a complete set of attendance sheets for only 24 (69 percent) of them.[6]

Although group facilitators are required to submit monthly attendance reports, no one at the diversion program is making sure that these reports are received.

The diversion program policies require group facilitators to submit monthly attendance reports. However, when we reviewed the files, it became clear that no one was making sure that these reports were submitted. The collection system manager said that although she files the attendance reports, it has never been her responsibility to ensure that all attendance reports are received. The program administrator explained that the case managers are responsible for ensuring the receipt of attendance reports. However, this view neglects the fact that not all case managers are located at program headquarters, where the files are to be stored. In addition, program management has a responsibility to ensure that case managers are performing the duties required of them.

The Level of Compliance for Therapist Reports Is Poor

The diversion program also requires some participants to attend individual therapy. In these instances, the participant is to ensure that the case manager receives written quarterly reports from the

[6] Of the five participants to whom this requirement did not apply, three were living out of state and two dropped out of the program prior to attending a diversion meeting.

therapist. If these reports are not received in a timely manner, policy states that case managers should follow up with participants or their therapists to make sure that reports are forwarded to the program. However, based on our review, it appears that case managers are not adequately performing these duties. For the sample of participants we reviewed, 51 therapist reports should have been received but only 17 (33 percent) actually were.

For the sample of participants we reviewed, 51 therapist reports should have been received but only 17 (33 percent) actually were.

Some written reports were not received because a new case manager was not following policy at the time and took verbal reports from therapists over the phone. However, a more frequent problem was that participants discontinued therapy without a formal amendment to their diversion agreement being processed and sometimes without even notifying the diversion program. For example, a board-ordered participant submitted a therapist report in August 2005 and discontinued therapy in October 2005 without notifying the program. In December 2005 the program should have noticed that no subsequent quarterly therapist report had been received for this individual. However, the program did not notify the participant until March 2006 that he was out of compliance, and it did not learn until a month later that this participant had stopped attending therapy. This participant and others were allowed to end the therapy required in their diversion agreements without having a formal amendment approved by a DEC. Although the discontinuance of therapy may not have led directly to a relapse, the physician in this example tested positive for alcohol in July 2006 and was terminated from the diversion program by December 2006 after testing positive for cocaine.

The Level of Compliance for Work-Site Monitor Reports Is Fair

Of the participants we reviewed, 18 were required to have work-site monitors. For these participants, the program had received 59 of the 78 required work-site monitor reports. Although these results are fair, there is room for substantial improvement.

It appears that new case managers do not always understand diversion program policies regarding work-site monitor reports. Specifically, the missing reports were for eight participants, three of whom had the same case manager, who was new to the program at the time. Instead of requiring written reports, the case manager was having conversations with work-site monitors over the phone. Although she documented in the Diversion Tracking System that these conversations had occurred, this documentation is deficient because it neither recorded what was said nor what time period the conversation covered. The case manager indicated that she now requires written reports from work-site monitors. Nevertheless, it should be noted that this new case manager was

not requiring written reports for at least a year, during which time program management was not aware of this issue and therefore never corrected it. This failure to require written reports indicates that program management has not created an adequate process to detect when case managers are not following policy.

In addition, it appears that work-site monitors are not always approved in advance by the diversion program. Prior to acting as a participant's work-site monitor, an individual agreeing to serve in this capacity must be approved by the case manager and must sign an acknowledgment form indicating that he or she will carry out the responsibilities of a monitor. In our review, we found that there was no acknowledgment form in the files of two participants and that files for three other participants had acknowledgment forms that were signed after the work-site monitors had already begun monitoring a physician. When these forms are not present or are filled out after the fact, the program cannot ensure that case managers have approved work-site monitors in advance and informed them of their responsibilities.

Further, the current work-site monitor agreement contains no conflict-of-interest language. According to a policy that took effect in July 2006, a work-site monitor shall have no business or personal relationship with the participant that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the diversion program. This policy was incorporated into a conflict-of-interest statement included in the program's new acknowledgment forms for work-site monitors. However, according to the Northern California case manager supervisor, these new forms have not yet been approved by the executive director's office of the medical board and remain to be implemented. These new forms, and enforcement of the relatively new policy, need to be implemented because we found that some participants' relationships to their work-site monitors would constitute a conflict of interest. Specifically, we found two work-site monitors who work directly for the physician they are to monitor. Thus, because their livelihood is at stake, fair reporting could be compromised.

We found two work-site monitors who work directly for the physicians they are to monitor.

Finally, the work-site monitoring could be improved if the diversion program had work-site monitors report on whether participants are complying with any work restrictions imposed by the program. Currently, the work-site monitoring reports do not convey whether work restrictions, such as a limit on the number of work hours, are being followed, and there is no indication that work-site monitors are even aware of these restrictions. In fact, we found only one instance in which the file of a participant contained any sort of positive assurance that work restrictions were being followed. If the diversion program leveraged the existing work-site monitoring

reporting procedures to gain information on compliance with work restrictions, the program could eliminate what is currently a potential weakness.

The Verification of Support Group Attendance Is Poor

In addition to weekly diversion group meetings, the diversion program requires participants to attend other support group meetings, such as Alcoholics Anonymous or Narcotics Anonymous. In some instances, the program requires the participant to provide verification of meeting attendance in the form of signed attendance cards. Of the 37 in-state participants whose files we reviewed, 26 were required to provide verification of meeting attendance. Of these 26, three have since successfully completed the program and their files have been purged of treatment records, including attendance cards, as required by state law. Of the remaining 23, we could obtain attendance cards for only 10 participants (43 percent). Rather than finding this information in the participant's files, we had to contact a number of case managers to obtain the attendance cards, and in some instances it was clear that the case managers received these cards only after our request. Despite the poor level of documentation, the overall attendance at support group meetings for the 10 participants we could review was quite good—approximately 90 percent.

Quite often the reason case managers gave for not obtaining attendance cards was that they were not sure that the requirement was still in effect. The program administrator explained that verification of attendance at support group meetings is often an initial stipulation in diversion agreements, but that after a period of time the verification requirement is no longer applicable; however, an amendment is not always made to document this change. This practice explains why case managers were not sure whether the requirement was still in effect. Therefore, it appears that the lack of formality in documenting participants' current program requirements leads to uncertainty among diversion program officials and reduces the accountability to which participants and program personnel can be held.

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Moreover, even when it was known that a participant was to provide verification of attendance at group meetings, some case managers simply did not hold participants accountable for this requirement. For example, one participant provided her case manager with attendance cards in which she initialed next to the dates on the cards that she had attended support groups for more than a six-month span. She did not, however, specify which groups she attended and did not obtain the initials of a group secretary as she had done in the past and as required in the instructions on

the card. The case manager acknowledged that the participant should have noted which meetings she attended but said he was confident, based on his contacts with and clinical observations of this participant and his conversations with her group facilitator and diversion group peers, that she was attending her support group meetings.[7] Finally, he added that "to verify any participant's attendance at [support group meetings] is not always possible. It is . . . essentially an 'honor system.'"

We disagree with this case manager's assessment, however. Attendance cards provide verification of support group attendance, and case managers should make sure that they are submitted correctly. Further, it is troubling that a diversion program official whose primary responsibility is to monitor physicians' compliance with their diversion agreements would not do so in this instance. The approach displayed by this case manager illustrates the reason that program management should ensure that case managers are adequately performing their assigned role.

The Diversion Program Eases Program Requirements for Some Participants Despite Their Noncompliance With Reporting Elements

Despite statements and policies to the contrary, the diversion program grants some participants reductions in the number of diversion meetings they are required to attend and increases in the number of hours they are allowed to work, even when the participants are not in full compliance with the reporting components of their diversion agreements. In the November 2004 interim report, the enforcement monitor found that the diversion program lifted participants' work restrictions despite deficiencies in the submission of work-site monitor reports and, in reference to lapses in therapist reports, said that it does not appear that participants are ever sanctioned or penalized in any way for failure to comply with diversion agreements. In the November 2005 final report, the enforcement monitor reported that program management had responded to these deficiencies by instituting a policy that work restrictions would not be lifted and drug testing would not be decreased if a participant is not in compliance with reporting requirements.

The enforcement monitor reported that the program instituted a policy that program requirements would not be lifted if a participant is not in compliance with reporting requirements. We searched for this policy and found no written record of it.

During our review, we searched for this policy and found no written record of it. However, we did find the principle behind it embedded within a policy, which stipulates that only participants with continuous compliance with their diversion agreements will

[7] As we have used the term, support group meetings are Alcoholics Anonymous or Narcotics Anonymous meetings that participants are often required to attend in addition to the diversion group meetings that are facilitated by a group facilitator.

be considered for a reduction in diversion meetings after the first few years. Despite this policy and the diversion program's earlier statements to the enforcement monitor, we found five instances in which participants received reductions in program requirements despite being out of compliance with the reporting components of their diversion agreements. In two of these instances, the program increased the number of hours physicians were allowed to work despite the fact that they were out of compliance with work-site monitoring requirements. For example, in October 2006 a diversion program DEC increased the number of hours a physician could work from 20 to 32 hours a week, even though the physician had not had an approved work-site monitor for three months and had not submitted a required work-site monitor report.

The diversion program increased the number of hours a physician could work even though the physician had not had an approved work-site monitor for three months and had not submitted a required work-site monitor report.

For the three other participants, the program granted their requests to attend one group meeting per week instead of two, despite the fact that they had not submitted quarterly reports from their work-site monitor, therapist, or both. In one of these cases, the diversion program allowed the participant to reduce the number of group meetings in July 2006 after receiving only one work-site monitor report for the previous nine months. The participant later relapsed in October 2006. Although this reduction in diversion meetings, despite a record of noncompliance, did not necessarily set up the conditions for the relapse, it certainly did not send the appropriate message to this individual. Rather, the message sent to these participants is that program requirements are not always tracked and enforced.

Overall, Participants Appear to Receive the Required Number of Drug Tests

The diversion program required the participants in our sample to take between two and six random drug tests each month. Between November 2005 and October 2006, we found that our sample of participants generally received the number of drug tests required by their diversion agreements. Specifically, 1,100 drug tests were required in our sample and 1,084 (99 percent) were actually taken. However, it should be noted that some participants took more than the required number for various reasons, and these additional tests balanced out the number of tests that a few participants did not receive. Further, as we describe in Chapter 2, a number of drug tests were performed on dates other than the ones that were randomly selected. Consequently, although the overall results from our sample indicate that the diversion program is doing well in having required drug tests completed, there is need for a number of improvements that we describe in detail in the next chapter.

The Diversion Program Has Reduced the Time It Takes to Bring New Participants Into the Program

Although it is still meeting only two of its three goals in this area, the diversion program has made substantial improvement in the timeliness of its initial evaluation of prospective participants. The diversion program's established goal, when a physician initially contacts the diversion program and a telephone intake interview is completed, is to have the prospective participant meet with a case manager and complete his or her first drug test within seven days. After participants sign a standard interim agreement with the case manager and begin drug tests and group meetings, the diversion program has them finish the evaluation phase of the program by meeting with a DEC so that an individualized diversion agreement can be developed and later signed. The diversion program's goal is to have participants meet with a DEC within 90 days of the telephone intake interview. As will be discussed further in Chapter 3, the diversion program provides ongoing reports to the medical board on the results of its efforts to achieve these goals.

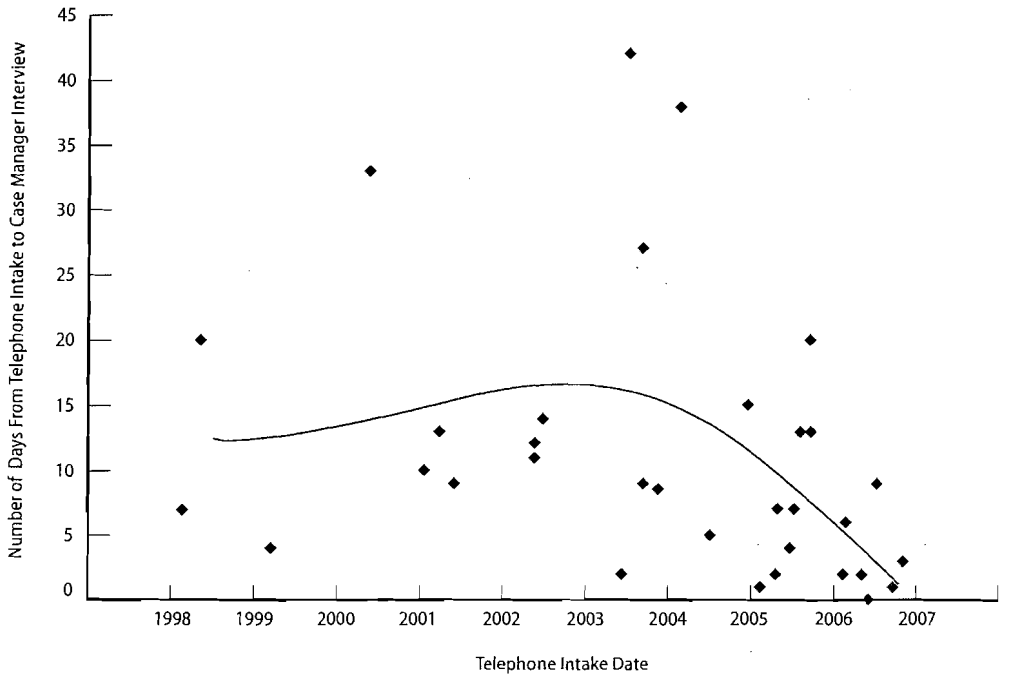
Using our random sample of participants, we determined how well the diversion program was meeting its goals and found that for all three areas—timeliness of case manager intake interviews, first drug tests, and first DEC meeting—the program has reduced the number of days it takes to accomplish these tasks in recent years. In fact, for case manager interviews and first DEC meetings, the diversion program appears to have met its goals, on average, in 2005 and 2006. However, although dramatically improved, the timeliness of first drug tests continues to lag behind the program's stated goal. Nevertheless, the overall improvement the program has made in moving participants through the evaluation phase in a timely manner should be commended. This improvement demonstrates the value of establishing, striving for, and reporting on performance goals—a subject that is further discussed in Chapter 3.

Case Managers Have Been Contacting Prospective Participants in a Timely Manner in Recent Years

When a physician contacts the diversion program, an analyst at program headquarters conducts a telephone intake interview and then notifies the appropriate regional case manager. The case manager is to then contact the prospective participant and complete a face-to-face intake interview within seven days. As indicated in Figure 4, the case managers have not always performed this task in a timely manner. For example, for the seven participants in our sample who contacted the program in 2003 or 2004, the average number of days case managers took to complete their interviews was 19. However, as indicated by the trend line in

Figure 4, the diversion program has dramatically decreased the time it takes to conduct a case manager intake interview. In fact, the average number of days for the 16 participants in our sample who contacted the program in 2005 and 2006 was seven. Based on these results, the program appears, on average, to be meeting its stated goal for timeliness of case manager intake interviews.

Figure 4
Timeliness of Case Manager Intake Interviews for Sample of Physician Diversion Program Participants



Source: Auditor analysis of information obtained from a sample of participant files of the Physician Diversion Program.

Note: This figure contains 33 data points instead of 40 because our sample included three out-of-state participants who were monitored by parties in other states. In addition, two participants dropped out of the program prior to a case manager intake interview being conducted and two participants had case manager intake interviews prior to the initial telephone intake.

There are various reasons for the length of time it took for case managers to conduct intake interviews in 2003 and 2004. As we discuss in the Introduction, the diversion program delayed some participants' entry into the program during 2003 and 2004 to ease the caseload of case managers in some areas. This delayed entry accounts for the highest data point in Figure 4. Other reasons that case managers did not contact participants in a timely manner included having an insufficient number of case managers in the past and waiting for participants to receive approval from enforcement to participate in the program. To decrease the time it took for case managers to complete their intake interviews, the

diversion program ended the delayed entry policy, hired additional case managers, and started contacting prospective participants immediately for an intake interview rather than waiting for final approval from enforcement.

Although the Length of Time Before a Participant's First Drug Test Does Not Appear to Meet Program Goals, Substantial Improvement Has Been Made

The average length of time before a participant's first drug test was 18 days—well exceeding the program's target time frame of seven days but showing improvement.

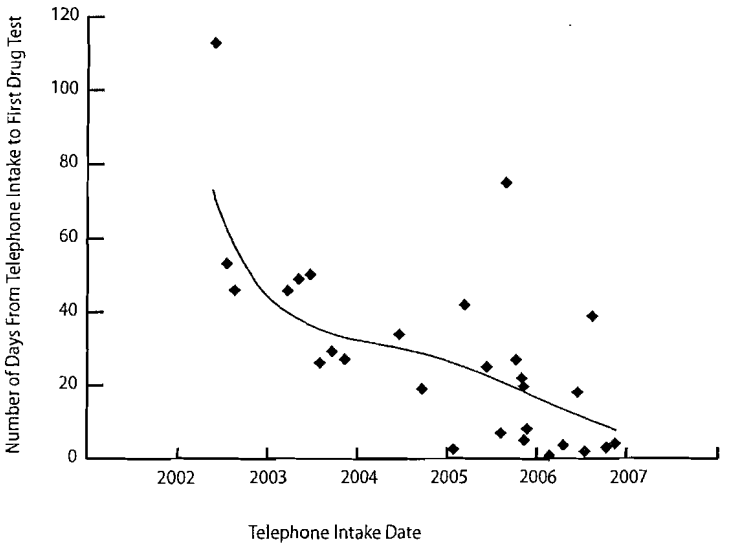
Once a telephone intake interview with a prospective participant is completed, a diversion program analyst notifies the collection system manager to schedule the physician for random drug tests. In 2005 the program established a target time frame of seven days after the telephone intake for completing the first drug test. As indicated by the trend line in Figure 5, the program had difficulty even approaching this goal in the past, but it has dramatically improved in recent years. For our sample of participants who contacted the program in 2005 or 2006, the average length of time before their first drug tests was 18 days—well exceeding the goal but representing a marked improvement over the 2003 and 2004 average of 35 days.

In reviewing the reasons why some initial drug tests were not completed in a timely manner, we found that in the past diversion program personnel would not immediately schedule a participant for drug tests if they knew that the individual would be entering a residential treatment center in the near future. In fact, they would delay drug tests even when the participant was not scheduled to enter treatment for several weeks. The diversion program has since changed this policy and now has the collection system manager schedule drug tests immediately after the initial phone call from the participant. In the past, program personnel would also sometimes not schedule drug tests while the participant was being treated by an outpatient treatment center in California—a circumstance that nevertheless would still allow for drug testing. Finally, another reason first drug tests were not always completed in a timely manner was that program personnel failed to schedule the tests immediately after a participant was released from treatment.

The program administrator explained that it is the policy of the diversion program to perform drug tests when possible, which would include when the participant is in outpatient treatment. He indicated that when testing is not possible because the participant is in residential treatment, the policy calls for resuming drug testing quickly after the participant gets out. He further explained that, although such errors could still exist to a limited extent, the program has made strides in eliminating delays in drug tests due to scheduling errors. He attributed part of this improvement

to changes in policy but stated that he believes setting the goal to complete the first drug test within seven days and reporting on these efforts, starting in April 2005, has been the driving force behind the policy changes and the improvements the program has experienced.

Figure 5
Timeliness of First Drug Tests for Sample of Physician Diversion Program Participants



Source: Auditor analysis of information obtained from a sample of participant files of the Physician Diversion Program.

Note: This figure contains 28 data points instead of 40 because our sample included three out-of-state participants who were monitored by parties in other states. In addition, of the 37 in-state participants in our sample, there were seven participants who entered the program over six years ago and the date of their first drug test could not be determined. There were two others who dropped out of the program prior to a drug test being conducted.

The Diversion Program Appears to Be Achieving Its Goal of Having Participants Meet With a DEC Within 90 Days

Until participants can meet with a DEC, they operate under a standardized interim agreement. The diversion program's goal is to have participants meet with a DEC within 90 days so that an individualized program plan can be developed and agreed upon. Adjusting for time during which the diversion program must wait for approval from enforcement for some participants, the program did quite well in achieving this goal for our sample of participants. For the participants who contacted the program in 2003 or 2004,

the average length of time before their first meeting with the DEC was 86 days. The average for the 2005 and 2006 participants in our sample improved to 64 days.

According to state law and medical board policy, physicians who have an open enforcement investigation cannot go before a DEC for formal program acceptance until enforcement has approved their participation in the diversion program. Fourteen of the participants in our sample had to wait for enforcement approval prior to appearing before a DEC. For example, one participant's formal acceptance into the program was delayed for 14 months while waiting for enforcement approval.[8] Because the diversion program has little to no control over the length of time it takes enforcement to approve such physicians' entry into the program, we subtracted wait times of this type from our calculations.

The Diversion Program Fails to Ensure a Timely and Adequate Response to Potential Relapses

State law requires the diversion program to ensure that participants have at least three years of continuous sobriety in order to successfully complete the diversion program. To enable it to monitor their sobriety, the program requires participants to submit randomly scheduled urine samples each month and analyzes these samples to determine whether they contain unauthorized drugs. In some cases, participants try to hide their drug use by increasing their fluid intake, thereby diluting their urine. This is known as a negative dilute. We analyzed drug test results obtained between November 2005 and October 2006 for our sample of 40 participants and found that, of the 1,084 drug tests administered, 32 were reported as positive for drugs and 11 were considered negative dilutes.[9]

Because these test results provide the diversion program with a strong indication that a participant may have relapsed into drug abuse, it is critical for the program to respond quickly and adequately in these instances. However, we found that in some instances the program did not respond in a timely manner and did not demonstrate that its actions were adequate, thus putting the public's safety at risk. Specifically, the diversion program did not always require a physician to immediately stop practicing medicine after testing positive for alcohol or a nonprescribed or prohibited

[8] We did not evaluate why enforcement was not able to provide approval sooner because we considered this to be outside the scope of the audit we were asked to conduct.

[9] When a negative dilute occurs, program policy requires participants to receive another drug test but does not specify how quickly this test should occur. For each of the 11 negative dilutes in our sample, an additional test was completed within a day or two of the reported result.

drug, as required by program policy, determined that positive drug tests were not a relapse without providing any justification for such a determination, and failed to have a trained medical review officer review contested results.

The Diversion Program's Actions Following a Participant's Relapse Have Not Always Been Timely or Adequate

The diversion program failed to follow program policy when it allowed physicians to continue practicing medicine after being notified of positive drug test results. Further, the diversion program has not established written protocols for its communication with enforcement and has consequently not always followed the practice the program administrator says should be employed. According to state law, the diversion program's top priority is to protect the public. In order to fulfill this priority, the diversion program's policies prohibit any participant who tests positive for prohibited drugs or alcohol from practicing medicine until the program can further analyze the positive drug test result and determine whether the physician can return to work. The program administrator stated that if a physician tests positive for a drug, even if the drug is prescribed, the program pulls the physician from work immediately, unless the prescribed medication is authorized. In addition, the program administrator indicated that the physician is not allowed to return to work until he or she receives two consecutive clean drug tests after the work suspension. Although in some cases the diversion program allows participants taking prescribed drugs to practice medicine, the program has determined that they cannot do so when the drug is on a list that it provides to physicians when they enter the program. Of the 32 instances in which participants tested positive for a prohibited drug, 13 involved physicians who were practicing medicine at the time. Although the diversion program should have removed all 13 physicians from work immediately, it did so for only three. Six others were removed within periods ranging from two to 14 days, and the program did not remove four of them from work at all.

Of the 13 practicing physicians who tested positive for a prohibited drug, the program immediately removed only three from work.

Of the four instances in which the diversion program did not remove a practicing physician from work, three related to drugs that were prescribed to the physician that are on the program's list of drugs that participants cannot use while practicing medicine, and one related to a drug that was not prescribed that the participant claimed was taken by accident. In each instance, policy required the program to remove the physician from work until he or she was no longer under the influence of the prohibited drug or until the reasons for the positive drug test result could be determined, but the program did not do so.

For example, the diversion program failed to remove a physician from work who tested positive for a particular prohibited drug on two separate occasions, once in December 2005 and again in August 2006. The program did not determine either instance to be a relapse. In the first instance, the physician had more than 10 times the cutoff level needed for a positive result. He notified the program after being tested that he may have unknowingly taken the drug because his wife accidentally placed the drug in a common pain reliever container. The case manager at the time indicated that she used her judgment and did not pull the participant from work or consider the positive result as a relapse based, in part, on the participant's past history of not testing positive. The program administrator agreed that the case manager did not follow program policy and should have consulted with others concerning the positive result. In the second instance, the physician tested positive for the same drug but this time had a prescription. However, despite the case manager's assertion that the physician did not return to work until he was off this pain medication, the physician indicated that he returned to work shortly after testing positive for the drug. This may indicate that he was under the influence of this drug while practicing medicine. The diversion program should have ensured that he was not under the influence by having him complete two drug tests with negative results prior to returning to work, as policy prescribes.

Despite the case manager's assertion that the doctor did not return to work until he was off this pain medication, the doctor indicated that he returned to work shortly after testing positive for the drug.

In the instances in which the diversion program removed practicing physicians with positive drug tests from work, it did so immediately, as required, in only three instances. In one example, the program allowed a physician to work for 14 days after the lab reported that the participant had tested positive for alcohol in February 2006. According to information contained in the participant's file, a case manager confronted the physician with the results and the physician denied the use of alcohol, stating that he had consumed barbecue sauce that may have contained alcohol. Although the program administrator stated that it is the program's policy to immediately remove the physician from work until the reasons for the positive result could be determined, the program did not do so until after the physician tested positive for alcohol again and also tested positive for a painkiller for which the physician had a prescription. In part because of concerns over the physician practicing medicine while under the influence of this painkiller, the case manager asked the participant to stop working 14 days after the original test result was received.

Although in this example, removal from practice occurred 14 days after the date the diversion program received the first positive drug test result from the lab, it should be noted that, because of the time lag between urine collection monitors (collectors) submitting test samples and the lab posting the test results to the program, the first

positive drug test had actually occurred 21 days before the physician was removed from work. Because of the time it takes to ship urine samples and to analyze them, a lag in receiving drug test results is unavoidable to some extent. However, in 10 of the 43 positive or negative-dilute test results we reviewed, the lag exceeded seven days. The diversion program indicated that for the period of January through March 2007, receiving results could still take as long as a week. This lag time makes it even more critical that the diversion program immediately remove physicians from work when they have tested positive for alcohol or a nonprescribed or prohibited drug. When it does not do so, the diversion program endangers those patients a physician sees while potentially under the influence of drugs or alcohol.

In another example, although the enforcement monitor recommended that it do so, the diversion program has not yet developed protocols for its communications with enforcement. According to a prior policy manual, the program must notify enforcement when a board-ordered participant relapses into chemical use. Further, the participants' standard agreements with the diversion program stipulate that the lab results of board-ordered participants will be forwarded to enforcement. The program administrator clarified that only positive results are communicated to enforcement. However, we found that one board-ordered participant had positive drug test results in May and July 2006, and in fact was determined to have relapsed in both instances, yet enforcement was not notified until December 2006 when he relapsed again and was terminated from the program. This example highlights the need for the program to develop written protocols. The program administrator agreed that such protocols need to be developed so that all program staff know what information needs to be shared with enforcement.

One board-ordered participant had positive drug test results in May and July 2006, and in fact was determined to have relapsed in both instances, yet enforcement was not notified until December 2006.

The Diversion Program Does Not Adequately Justify Its Determination That a Positive Drug Test Is Not a Relapse

When the program determines that a physician has relapsed, diversion program policy requires case managers to document the positive drug result. The documentation provides information concerning the positive test and insight into why it was considered a relapse. However, no such documentation or justification is required when the program determines that positive drug test results or other indications of drug abuse do not constitute a relapse. As a result, the diversion program has less assurance that its decisions regarding whether a physician has relapsed are correct and consistent. These decisions are important because a participant cannot successfully complete the program unless he or she has had no relapses in three years. Additionally, program policy requires the

By not documenting why it determined that a particular positive drug test result was not a relapse, the program risks allowing participants to graduate without three years of sobriety.

DECs to consider program termination for any physician who has had three or more relapses. Consequently, by not documenting why it determined that a particular positive drug test result was not a relapse, the program risks allowing participants to graduate without three years of sobriety and also risks not terminating a physician with numerous relapses soon enough.

For example, one participant in our sample, who graduated from the diversion program in December 2005, tested positive for alcohol in March 2004. According to the case file, an anonymous caller notified the program that the participant was drinking alcohol while away on out-of-town trips. As a result, the program immediately ordered a drug test. The test results indicated that the participant had more than three times the cutoff level needed for a positive result for alcohol. Despite this evidence, the program did not determine that this instance constituted a relapse. Further, it did not, and was not required to, justify this decision. The participant graduated from the program 21 months later. We reviewed this instance with a case manager supervisor who, at the time the physician graduated from the program, was acting as the case manager, and she agreed that the program should document the reasons that a positive test result is not considered a relapse. She indicated that she will, in conjunction with the program administrator, consider adding this requirement to diversion program policies.

The Diversion Program Does Not Have Contested Drug Test Results Evaluated by a Trained Professional as Recommended by a Panel of Experts and Its Own Diversion Committee

Despite the continued recommendations of a panel of experts the diversion program used to provide it with advice (liaison committee) and the recommendation of its diversion committee, the diversion program does not have a qualified medical review officer (MRO) review drug test results that are contested by participants. Consequently, the diversion program may have less assurance that its decisions regarding whether a positive drug test result constitutes a relapse are valid. According to its February 2005 meeting minutes, the liaison committee asked the diversion program administrator for an update on the hiring of an MRO to review participants' drug test results. In November 2005 the liaison committee reiterated its desire that an MRO be hired, especially in those instances in which a participant contests a positive drug test result. Although we did not obtain the exact date on which the liaison committee first recommended the hiring of an MRO, the current diversion program administrator explained that, prior to his arrival in January 2005, the liaison committee had already recommended that the diversion program have an MRO

review drug test results, and that the diversion committee had recommended the hiring of an MRO. However, as of June 2007, the diversion program has yet to use or hire such a consultant.

Obtaining the opinion of a qualified MRO would help the diversion program determine whether a positive drug test result is a relapse. When physicians in our sample were confronted with a positive drug test result, some admitted to relapsing, but a more common response was to deny taking the prohibited substance that the test identified. Of the eight disputed results in our sample, the diversion program, or the DECs that assist the program with these decisions, considered half of them not to be relapses. In these instances, the reasons offered by the participants, and apparently accepted by the program, included the following:

Because many participants deny taking prohibited substances, obtaining the opinion of a qualified medical review officer would help the diversion program determine whether a positive drug test result is a relapse.

- A pharmacy must have incorrectly filled a prescription, dispensing a prohibited drug for which the participant later tested positive.

- The wife of a program participant accidentally placed a powerful prescription drug in a common pain reliever container. The physician later consumed this drug, apparently thinking it was the common pain reliever, and subsequently tested positive for it.

- A participant denied drinking alcohol, stating that she is not inclined to do so in general.

Certainly, an MRO would not have been able to directly ascertain the truthfulness of these explanations, but having a person specifically trained to independently analyze drug test results, and additional information in the participant's file, would allow the diversion program to better ascertain whether the reasons offered were at all consistent with the results. Further, in those cases in which the diversion program determines that a positive drug test represents a relapse, despite the explanation offered by the participant, the program's position would be bolstered by having the documented opinion of a qualified MRO.

Although he generally agreed that an MRO should be hired to review contested results, the program administrator stated that no MRO has yet been hired because the individuals on the list of candidates the liaison committee provided either did not possess desired certificates or did not want to work part time. The liaison committee has since been disbanded, and the program administrator stated that he does not plan to hire an MRO until the replacement for the liaison committee is reconstituted. The program administrator said that, in the meantime, the diversion program would continue to use lab personnel when it has questions concerning a positive drug result. Although the program indicates

that it utilizes lab personnel for advice on drug test results, the program administrator agrees that an MRO would be advantageous to provide an independent review. In addition, an advisory committee to the program in November 2005 reiterated how important it feels an MRO is to the process of evaluating lab results.

Recommendations

To better monitor diversion program participants, program management should create mechanisms to ensure that group facilitators, therapists, and work-site monitors submit required reports, and that participants submit required meeting verifications. When such documentation is not received, program management should have case managers make an effort to obtain this information.

The diversion program should institute a formal policy to increase or refuse to reduce the frequency of diversion and support group meetings and drug tests when a participant neglects to provide required documentation. In addition, the program's policy should include a provision to not lift or reduce work restrictions unless a participant is in full compliance with work-site monitoring requirements.

To eliminate uncertainty regarding individual participants' requirements, the program should process a formal amendment to a participant's diversion agreement if the program determines that a requirement should be changed for that physician.

To ensure that work-site monitors provide unbiased and complete reports, the diversion program should do the following:

- Ensure that each participant's work-site monitor is approved in advance and has no relationship with the participant that would impair his or her ability to render fair and unbiased monitoring reports.
- Ensure that the newly developed work-site monitor agreements containing conflict-of-interest language are approved by the medical board's executive office and signed by all work-site monitors.
- Notify work-site monitors of any work restrictions imposed on the participant they are monitoring, and direct them to report on compliance with these requirements.

To ensure that participants receive program services on a timely basis, the diversion program should continue its efforts to achieve the goal of completing participants' first drug tests within seven days of their intake interview.

To ensure a timely and adequate response to positive drug tests or other indications of a relapse, the diversion program should do the following:

- Immediately remove practicing physicians from work upon receiving notice of a positive drug test.
- Provide sufficient justification when it determines that a positive drug test does not constitute a relapse.
- Have the reconstituted liaison committee assess the need to have an MRO evaluate disputed drug test results and hire such an individual if it determines that this action is needed.

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Chapter 2

THE PHYSICIAN DIVERSION PROGRAM'S OVERSIGHT OF RANDOM DRUG TESTS AND ITS SERVICE PROVIDERS IS INADEQUATE

Chapter Summary

The Physician Diversion Program (diversion program) of the Medical Board of California (medical board) has not adequately overseen its drug-testing system and the service providers it uses to monitor and treat program participants. Specifically, although the diversion program appears to have improved in the drug-testing area in recent years, a large number of tests are still not being performed as randomly scheduled. The most frequent reason drug tests were not completed as scheduled was because of vacations requested by participants. However, a significant portion of these requests never received approval from appropriate program personnel. Other reasons drug tests were not completed as scheduled were that urine collection monitors (collectors) moved the tests to other dates, and that participants did not show up to take the tests. However, the program did not document the instances of inadequate performance by collectors and did not ensure that collectors submitted incident reports for each missed test, as required by program policy.

Further, the diversion program's current process for reconciling its scheduled drug tests with the actual drug tests performed does not adequately or quickly identify missed drug tests or data inconsistencies between collectors' reports and lab results. Finally, although the diversion program relies heavily on its collectors, group facilitators, and diversion evaluation committee (DEC) members in the monitoring and treatment of its participants, it has not been formally evaluating these individuals to determine how well they are meeting program standards.

Many of the Participants' Random Drug Tests Were not Completed as Scheduled

Prior to the beginning of each month, the collection system manager uses a random date generator within the Diversion Tracking System (DTS) to create a calendar of all the participants' drug tests for the upcoming month. A copy of the calendar is then sent to each collector, case manager, and diversion group meeting facilitator. The purpose of randomly selecting drug test dates is so that participants cannot anticipate when a test will be given and have an opportunity to affect the outcome of the test.

For the two months tested, 74 percent of the drug tests scheduled were completed on their randomly chosen dates.

Although there are indications that the diversion program is improving in this area, many drug tests are still not being performed on the dates selected by the program's random date generator. In November 2004, which was prior to the implementation of the current version of the DTS and also prior to the hiring of the current full-time collection system manager, the enforcement monitor reported that only 40 percent of the 378 scheduled drug tests she reviewed were completed as scheduled. We found that for the months of June and October 2006, 74 percent of the 1,692 drug tests scheduled were completed on their randomly chosen dates. This indicates that the diversion program has made some progress in having drug tests completed as randomly scheduled. However, as we describe later, the current system still has a number of deficiencies that need to be corrected. As a result of these deficiencies, some participants may be able to determine patterns in their drug testing and engage in substance abuse such that the opportunity to detect their abuse expires prior to their drug tests. Further, because the diversion program grants vacation requests that have not been planned and approved in advance, some participants could relapse and then request an unplanned vacation to avoid detection. In fact, these deficiencies caused one participant to comment in a program-conducted survey regarding drug tests, "Mine wasn't very random—I was able to 'game' it for several years and almost 'graduated' while still using."

Of the 1,692 total drug tests scheduled in June and October 2006, 439 were not completed on their scheduled date. As shown in Table 3, vacation requests were the most common reason for a participant not having a drug test on the randomly selected date, representing about 46 percent of all drug tests not completed as scheduled. As we will discuss later, a significant number of these requests were granted without appropriate approvals from program officials. Other reasons drug tests were not completed as scheduled were that collectors performed the drug test on a different date (27 percent), participants were in residential treatment (14 percent), the participant missed or refused to take the test on that date (5 percent), and the collector failed to complete the ethyl glucuronide portion of the scheduled test, which specifically tests for alcohol consumption (3 percent).

The Diversion Program Rescheduled Drug Tests Based on Unapproved Vacation Requests From Participants

The diversion program's current policy states that participants must submit a vacation request to their case manager, or to their group facilitator if they will miss any group meetings, at least two weeks in advance in order to have their random drug tests

Table 3
Number of Drug Tests Not Completed as Scheduled in June and October 2006

		NUMBER OF DRUG TESTS NOT COMPLETED AS SCHEDULED DUE TO:				
			PARTICIPANTS			
MONTH	NUMBER OF DRUG TESTS NOT COMPLETED AS SCHEDULED	PARTICIPANT IN TREATMENT	VACATION (WITH PROPER APPROVAL)*	VACATION (WITHOUT PROPER APPROVAL)	COLLECTOR†	OTHER‡
June 2006	244	29	82	20	79	34
October 2006	195	34	74	22	39	26
Totals	439	63	156	42	118	60
Percentage of drug tests not completed as scheduled		14%	36%	10%	27%	14%

Sources: Auditor analysis of the June and October 2006 drug test calendars, lab results, and collectors' reports.

* This column includes 48 drug tests that did not have corresponding approved vacation request forms but rather had entries by the case managers in the program's diversion tracking system.

† This column includes seven tests that were rescheduled by the collection systems manager to make sure that a test was performed each week and to ease the weekend work of collectors.

‡ This column includes 24 drug tests that were not completed as scheduled because the participant missed or refused to take a drug test (5.5 percent), 12 drug tests not completed as scheduled because the collector failed to administer the ethyl glucuronide portion of the test to detect alcohol consumption (3 percent), and 24 drug tests not completed as scheduled for reasons that could not be determined (5.5 percent).

rescheduled. Despite this policy, we found that of the 198 drug tests that were rescheduled because of vacation requests in June and October 2006, 42 (21 percent) were related to requests that never received approval. In some instances, participants sent vacation requests directly to the collection system manager, who then rescheduled the test dates. Thus, these requests did not receive the scrutiny of appropriate program officials.

In addition, although we counted them as approved in Table 3, another 48 vacation requests did not have signed and approved vacation request forms but rather had corresponding entries in the DTS in which the case manager acknowledged receipt of the vacation request. The program administrator said it is understood by the case managers that entering vacation dates into the DTS is equivalent to approval. Although this may be true, the current collection system manager stated that it is not part of her regular process to check the DTS to see if a case manager has approved a vacation request and that she does not have the time to verify with case managers that all vacation requests have been approved. Consequently, although it appears that the case managers were aware of these 48 vacation requests, the randomly selected drug tests were being rescheduled without assurance that case managers had in fact approved the rescheduling. Therefore, although 42 vacation requests in our sample had no approval, there was an

even higher number of vacation requests for which the collection system manager had no indication that the request had been approved—yet the scheduled drug tests were moved anyway.

For example, in June 2006, the collection system manager rescheduled a participant's test due to a vacation request. However, the group facilitator and case manager never approved the vacation request, as the form is blank where their signatures should have been. Despite the fact that the approval portion of the form was blank and there was no entry in the DTS indicating that the case manager was aware of the request, the collection system manager considered the request approved and moved the participant's test date.

We also found that 14 of the 42 vacation requests without approvals were faxed directly from the participants to the collection system manager.

Although we could not determine the transmittal of every vacation request, we also found that 14 of the 42 vacation requests without approvals were faxed directly from the participants to the collection system manager. For example, in June 2006, one participant faxed a vacation request directly to the collection system manager, who then moved the scheduled test to another date. Although there was no signature of either the group facilitator or case manager on the form, the participant had checked the box stating that the request was approved. On the form, it appears that the participant hand-wrote the names of the group facilitator and case manager (instead of obtaining their signatures). There was no sign of any correspondence between the case manager and participant about this vacation request in the DTS. Because participants can, if they are so inclined, make the request appear to have been signed and approved, the collection system manager should not be receiving vacation requests directly from participants.

We also found that 13 of the 156 approved vacation requests had signatures only from the group facilitators. Although this is deemed to be sufficient approval under current policy, we believe that participants should also receive approval from their case managers, because case managers are the program officials charged with monitoring the participants assigned to them. In addition, group facilitators are not employed by the State and therefore cannot be held to the same standard of accountability as case managers.

Collectors Did Not Always Complete Tests on the Scheduled Dates

According to diversion program policy, collectors are to complete drug tests on the dates randomly scheduled and are to give the program 14 days advance notice if they will not be available to perform testing. If this notice is provided soon enough, the dates that collectors are not available are taken into account prior to the drug test calendar being prepared. Of the 439 drug tests not completed as scheduled in June and October 2006, 118 (27 percent)

were completed on a different date chosen by the collector. In 86 of these instances, the collectors notified the program prior to testing on a different date.[10] Even so, when collectors are allowed to move drug tests to dates that are more convenient for them, the diversion program runs the risk that a participant will gain an understanding of his or her collector's pattern and potentially allow the participant to time substance abuse so as not to be detected. For example, a collector was scheduled to test two participants on a Saturday in October 2006 but instead completed the tests on the Tuesday prior to the weekend date. In that same month, another collector also had two drug tests scheduled for a Saturday. This collector moved both tests to a Monday, nine days later. A third collector moved the two randomly selected Saturday test dates for one participant to the following Tuesdays. Although not all test dates moved by a collector were from a weekend to a weekday, these three examples illustrate a pattern that could develop if collectors are allowed to move randomly selected dates.

Of further concern is that collectors did not notify the diversion program in advance for 32 of the 118 drug tests rescheduled by the collector. In addition to potentially creating a pattern that participants can detect, these instances indicate a loss of control by the program that is further exacerbated by the fact that the program does not make note of these failures to follow program policy and does not formally evaluate its collectors (as we discuss later). To address this deficiency, in February 2007, the collection system manager sent a memo to all collectors stating that the diversion program will not tolerate changes in scheduled test dates without prior approval. The memo also stated that the new policy, effective February 2007, requires all collectors to submit a written request for any changes to scheduled collection dates at least two weeks in advance and that telephone calls alone will not be accepted.

The collectors did not always notify the diversion program in advance as required when rescheduling test dates.

Participants in the Diversion Program Missed Scheduled Test Dates for Other Reasons

As noted in Table 3 on page 41, we found that 60 drug tests scheduled during June and October 2006 were not completed as scheduled for a combination of other reasons. Specifically, 24 drug tests were not completed as scheduled due to a participant not returning a collector's phone call or refusing to take a drug test when contacted, 12 were not completed as scheduled because the

[10] Although available information did not allow us to determine whether collectors gave a 14-day advance notice in most of these instances, we were able to determine that advance notice was not given in 11 instances.

collector failed to administer the ethyl glucuronide portion of the test to detect the presence of alcohol, and 24 were not completed as scheduled for unknown reasons.

When a participant does not return a collector's phone call or refuses to take a drug test when contacted, the program's policy manual states that the collector is to notify the collection system manager immediately and submit an incident report explaining what happened to the case manager, collection system manager, and group facilitator within 24 hours. This alerts the collection system manager that a participant missed a test, which may need to be rescheduled. However, we found that there were incident reports for only 11 of the 24 drug tests (46 percent) that were missed, and not all of these reports were submitted in a timely manner. Of the 11 incident reports, five were submitted between two and three days after the participant missed the test, with remaining reports being submitted either the day of or the day after the missed test. For the remaining 13 missed drug tests, no incident reports were submitted.

If the collectors do not send in incident reports, the collection system manager has no way of knowing that a participant has missed a drug test until she reconciles the scheduled drug tests with the drug tests actually performed, which she does after the end of each month.

The collection system manager stated that if the collectors do not send in incident reports, she has no way of knowing that a participant has missed a drug test until she reconciles the scheduled drug tests with the drug tests actually performed after the end of each month. The collection system manager said that if she notices a missed test, she may contact the collector or case manager to find out why or check the DTS for any case manager entries regarding this issue. She indicated that after determining the reason for the missed test, she does not then require the collector to submit an incident report describing the event. We question this decision, because requiring collectors to submit these reports, even well after the event, would reinforce the program's policy by sending a message to collectors that it is important for them to send in their incident reports as required. Of further concern is that in the 11 instances in which the program received an incident report, the program's only response was to reschedule another drug test, even though the program's policy manual lists other steps that could be taken, such as removing a physician from work or increasing the number of drug tests the participant must complete each month.

In addition to the tests that participants missed, we could not determine why another 24 drug tests were not completed as scheduled. In these cases, the collector did not submit a monthly report or the monthly report did not explain why a test was missed. For these drug tests, we confirmed that the collection system manager did not have any vacation requests or incident reports on file for the participant.

In June 2006 one participant had four out of five of his tests rescheduled for unknown reasons. Because the participant did not submit a vacation request and the collector did not submit the June monthly report or any incident reports, we could not determine the reason for these changed dates. Also, because the collection system manager reconciles lab results only with collectors' reports, and not to the monthly calendar, she was not aware that the drug tests were not completed as scheduled and consequently did not have an explanation for these missed tests.

Some Tests Not Completed as Scheduled Were Never Made Up

Of the drug tests that were not completed as scheduled during the months of June and October 2006, the vast majority were made up on a different date; however, we found eight missed drug tests that were never made up. In these instances, the participants were not required to complete the requisite number of drug tests specified in their agreements.

For example, one participant took a drug test in June 2006; however, it was not reflected in the lab results because the collector sent the sample to the lab without the chain of custody form or payment for the test. Because the diversion program's reconciliations of scheduled drug tests with actual drug tests are not completed promptly, this error was not discovered until August 2006. To make up for this invalid test, the collection system manager intended to add an additional drug test for this participant in August 2006. We checked the August 2006 calendar and saw that the collection system manager had included a note on the bottom of the page stating that a makeup collection should be taken for this participant; however, the test was not added to the calendar itself. We also checked the August 2006 lab results and found that no additional test was taken. Further, there was no indication that this test would be rescheduled to another date. As a result, this missed collection was never made up.

Because the diversion program's reconciliations of scheduled drug tests with actual drug tests are not completed promptly, a June 2006 error by a collector was not discovered until August 2006.

The Diversion Program's Process for Reconciling Scheduled Drug Tests With Actual Results Needs to Be Improved

The diversion program's current process for reconciling its scheduled drug tests with the actual drug tests performed does not promptly identify missed drug tests or data inconsistencies between collectors' reports and lab results. In particular, the current process can be slowed by late collector reports and does not allow the program to confirm that drug tests added to the master schedule after its original distribution to the collectors have been completed. Further, program management has not been reviewing

the reconciliations to ensure that they are performed accurately and that there is adequate follow-up on discrepancies identified during the reconciliation process.

According to the program's policy manual, collectors are required to submit monthly reports to the collection system manager that include the participant's name and case number and a unique identifying number for each completed drug test. The reports should also cite the reason why a participant was not tested on an assigned date, if applicable. To check for consistency, this report is to be reconciled to the monthly lab results report and the calendar of randomly generated test dates. If discrepancies exist, the collector may be contacted for an explanation. Although the program's policy manual states that the monthly collector reports should be reconciled to both the lab results and the calendar, the current collection system manager reconciles the collector reports only to the lab results. As demonstrated below, not using the calendar as part of the reconciliation process causes a number of problems.

In June 2006 a collector's monthly report indicated that a particular drug test was completed as scheduled; however, the lab report had no record of this drug test.

For example, in June 2006, a collector's monthly report indicated that a particular drug test was completed as scheduled; however, the lab report had no record of this drug test. After we questioned program staff regarding this issue, they provided documentation indicating a drug test had been completed on the scheduled date but the collector had failed to write the identifying number on the sample submitted to the lab. Although a reconciliation of these reports should have discovered this error, program staff explained that they could not do the reconciliation at the time because the collector's report was not sent to them promptly. However, this view fails to recognize that the lab results could have been reconciled immediately to the calendar prepared by the collection system manager.

In addition to delaying the reconciliation, the practice of using the collectors' reports rather than the calendar introduces unnecessary risk to the process because the collectors' reports may not include all scheduled drug tests. In particular, some drug tests are scheduled after the randomly generated calendar is completed. These drug tests are manually added to the master schedule and the collectors are notified. If collectors fail to perform these tests, the manually added dates will not be shown on their reports. Also, these manually added drug tests are not reflected in the lab report, as it displays dates only from the randomly generated schedule. As a result, the current reconciliation process does not identify these missed collections.

For instance, in June 2006, after the schedule was created, the collection system manager manually added an additional test for one participant. However, the lab results show that this test was

never completed. The collector's report, which is filled out after the month is over, did not include this additional test date in the list of scheduled dates. Because the collection system manager's reconciliation process does not include checking the original calendar, which would include any tests added manually, she did not realize that this drug test was not performed.

The collection system manager stated that program management does not check her reconciliation each month. This could contribute to the inefficiency and ineffectiveness of the diversion program's reconciliation process, as management does not ensure that the collection system manager's reconciliation is complete and accurate or that she follows up on any issues discovered. Having someone check the collection system manager's work would provide stronger accountability in the reconciliation process.

The Diversion Program Does Not Formally Evaluate Its Collectors, Group Facilitators, and DEC Members

Although the diversion program relies heavily on its collectors, group facilitators, and DEC members in the monitoring and treatment of its participants, it has not been formally evaluating these individuals to determine how well they are meeting program standards. Collectors have not faced any consequences for rescheduling drug test dates and failing to submit required reports, group facilitators have continued to provide treatment services without demonstrating that they have a current license and meet continuing educational requirements, and some DEC members have had poor attendance at required meetings without being removed from their positions. In those cases in which the program did take action in response to noncompliance by its collectors, group facilitators, or DEC members, it often waited months or even a year before doing so.

The Diversion Program Does Not Evaluate Its Collectors

A critical component to ensuring that diversion program participants are sober, and to document instances when they are not, is the use of random drug tests. However, as we discussed earlier, collectors do not always follow through on the schedules of drug tests provided to them and sometimes make errors in submitting drug test documentation to labs. Even so, the diversion program does not document instances when collectors do not adequately perform their critical function and has not developed an evaluation mechanism for the 27 collectors it currently uses. In

The diversion program does not document instances when collectors do not adequately perform their critical function and has not developed an evaluation mechanism for the collectors it currently uses.

addition, diversion program collectors do not sign any contracts or agreements with the program but are simply sent copies of the collection procedures.

According to the collection system manager, the diversion program does not conduct any formal evaluations of the collectors' performance but is in the process of developing an agreement for the collectors. She explained that unless she hears complaints from the participants, she assumes that everything is okay. If she does receive a complaint, she first contacts the collector. The collection system manager then talks to the case manager, group facilitator, and program administrator, and together they decide whether the collector should be let go. Although this form of monitoring may identify collectors who mistreat participants, it does not evaluate, for instance, whether the collectors are completing drug tests on the randomly generated dates and submitting necessary paperwork to the labs. As a result, collectors have been able to reschedule drug-test dates and make critical errors without facing any consequences.

We also checked to see whether the collectors had complied with the requirement to submit the monthly collector's report. For the month of October 2006, the collection system manager received 23 of the 25 required reports. One of the collectors who did not submit a report for that month had not submitted a monthly collector report since March 2006. According to the collection system manager, the collector was continually late in submitting reports. Although she followed up with him, he still did not submit the reports. The program, however, did not replace this collector until March 2007, a year after he was noted as being noncompliant with the program's policies.

The Diversion Program's Group Facilitators Have Not Been Formally Evaluated in More Than 10 Years

According to the program administrator, evaluating the group facilitators has not been one of the diversion program's top priorities in recent years.

Although the diversion program's policy manual states that each group facilitator should be evaluated annually, no group facilitators have been formally evaluated since 1997. The program administrator indicated that he instead evaluates and monitors the group facilitators through informal conversations throughout the year. For example, the program administrator mentioned that he visited at least two meetings conducted by each of the 13 group facilitators during 2005 (the year he joined the diversion program) but indicated that he did not perform an evaluation or take written notes of these visits. According to the program administrator, evaluating the group facilitators has not been one of the diversion program's top priorities in recent years, since most of them have been facilitating groups for many years.

Even though the group facilitators have been in their positions for many years, it would still be valuable to evaluate their performance, especially since it is required in the diversion program's policy manual. Without formal evaluations, the group facilitators would not be made aware of whether they are fully meeting the expectations of the program. In addition, the program administrator mentioned that he has received some complaints about the group facilitators from participants and case managers. However, he attributes many of these complaints to differences in personal opinion. Although this could be the case, performing formal evaluations would create stronger accountability for the group facilitators and better ensure that they are meeting program standards.

The Diversion Program Does Not Appear to Ensure That Its Group Facilitators Stay Current With Required Licenses, Certifications, and Continuing Education

The diversion program does not do enough to ensure that its group facilitators hold a current license or certification, or meet their continuing education requirements. According to the current memorandum of understanding (MOU), which most group facilitators have signed, group facilitators must be California-licensed therapists "experienced in, and knowledgeable about substance-related disorders and mental health issues." According to the program administrator, group facilitators who were with the program prior to the enactment of this new MOU, can be certified by the California Association of Alcoholism and Drug Abuse Counselors rather than being a licensed therapist as the new MOU requires.

The program does not regularly confirm that group facilitators maintain active licenses or certifications.

A review of diversion program files indicated that of the 13 program group facilitators, nine are licensed marriage and family therapists or marriage, family, and child counselors; two are licensed clinical social workers; and two are certified alcohol and drug counselors. However, we observed that many of the copies of licenses and certifications in diversion program files were outdated, and some dated back to the 1970s and 1980s. This indicates that the program does not regularly confirm that group facilitators maintain active licenses or certifications. Consequently, the diversion program has less assurance that its group facilitators continue to be qualified to provide services to program participants.

The diversion program's policy manual states that the group facilitators must participate in at least two continuing education seminars in substance abuse, mental health, or group therapy every two years, and should provide verification of their participation to the diversion program. However, 11 of the 13 group facilitators' files did not contain any verification of continuing education. After we brought this to

their attention, program management obtained documentation from the group facilitators indicating that each had fulfilled the continuing education requirements. Nevertheless, the deficiency in documentation at the time of our review indicates that the program is not ensuring that facilitators are meeting these requirements.

The Diversion Program Did Not Evaluate Its DEC Members Between 2003 and 2007

Although diversion program policies require annual written evaluations of DEC members, the program did not perform these evaluations between 2003 and March 2007 (it completed its recent evaluations near the end of our review). Consequently, some members may not have been adequately performing their duties and were not replaced in a timely manner. During a 1999 medical board meeting, concern was expressed about the insufficiency of the evaluation process used at the time, which included tracking the DEC members' attendance and the time it takes them to respond to inquiries. As a result, a new procedure was developed requiring written evaluations of each DEC member that included ratings from other members of the committee on the member's preparedness, cooperation, communication, knowledge, clinical judgment, and interview skills. The evaluations were also to include data from diversion case managers about the timeliness and helpfulness of consultations, attendance records from the DEC coordinator, and comments and a summary from the program administrator.

Although the diversion evaluation committee member evaluations were approved in 2001, they were never added to the diversion program's policy manual, and the program stopped using the evaluation procedures after 2003.

Although the evaluation procedures were approved by the medical board's Division of Medical Quality in 2001, they were never added to the diversion program's policy manual, and the program stopped using the evaluation procedures after 2003. After that date, no formal evaluations of DEC members occurred until March 2007, during our review. This deficiency weakened the diversion program's ability to assess the performance of DEC members in the key areas previously outlined and potentially allowed individuals to continue to occupy a position on a DEC, even though they were not always performing all of their duties.

For example, in reviewing all of the DEC members' attendance records from November 2005 to October 2006, we found that eight out of 33 members (24 percent) missed two or more of their quarterly meetings. Although the DEC coordinator provided explanations for many of these absences, we found one instance in which the program responded slowly when a member had poor attendance. This member, who became the mayor of his town in November 2006, stopped attending DEC meetings after February 2006. Although the diversion program eventually replaced

the DEC member, it did not do so until March 2007. Collecting information for the formal evaluation process would have identified the need to replace this DEC member much sooner.

The current program administrator, who came to the diversion program in February 2005, explained that he does not know why evaluations of DEC members did not occur in 2004 but agreed that not having the evaluation requirements in the policy manual contributed to them not being performed in 2005 and 2006. He explained that in addition to immediately implementing the evaluations, he plans to get the requirements into the current policy manual as soon as possible.

Recommendations

To ensure that it adequately oversees participants' random drug tests, the diversion program should do the following:

- Change existing policy to require both the case manager and the group facilitator to approve all participant vacation requests prior to the rescheduling of any drug tests.
- Establish a control over the rescheduling of drug tests that prohibits the collection system manager from rescheduling drug tests without a properly approved vacation request and also prevents participants from submitting vacation requests directly to the collection system manager.
- Clarify the vacation request policy for participants, and incorporate the 14-day notice requirement for vacation requests into the participants' diversion agreements.
- Establish a more timely and effective reconciliation of scheduled drug tests to actual drug tests performed by comparing the calendar of randomly generated assigned dates to the lab results.
- Require a program manager to review the drug test reconciliation to ensure that it is complete and accurate.

To ensure that it adequately oversees its collectors, group facilitators, and DEC members, the diversion program should do the following:

- Document instances in which a collector moves drug test dates without receiving approval two weeks in advance, makes an error in the submission of a urine sample, or fails to file an incident report when required. In these instances, the collection system

manager should contact the collector, determine the cause of the noncompliance, and reiterate the need to follow program policy if necessary.

- Maintain updated files on group facilitators to ensure that they stay current with required licenses, certifications, and continuing education requirements.

- Formally evaluate collectors, group facilitators, and DEC members annually and take timely corrective action when these individuals do not fulfill their responsibilities.

Chapter 3

THE PHYSICIAN DIVERSION PROGRAM COULD BE IMPROVED THROUGH BETTER OVERSIGHT BY THE MEDICAL BOARD

Chapter Summary

The Physician Diversion Program (diversion program) of the Medical Board of California (medical board) lacks consistently effective oversight by the medical board, and its program structure overburdens its top manager. As indicated in the Introduction, the medical board uses a committee made up of some of its members to oversee the diversion program (diversion committee). However, the diversion committee's ability to oversee the program is hindered by a reporting process that does not give it a complete view of the program's performance and by a policy-making process that does not ensure that adopted policies are always added to the program's policy manual.

Consequently, rather than discovering deficiencies through the reporting process and correcting them through a policy-making process that maintains some level of continuity, the diversion committee has been notified of program deficiencies in recent years by an outside entity—the enforcement monitor (as described in the Introduction). As shown in the Appendix, the diversion program has made improvements as a result of the findings and recommendations issued by the enforcement monitor in her November 2004 interim and November 2005 final reports. However, almost two years after the final report, the diversion program has not fully implemented most of the enforcement monitor's recommendations. In one instance, the medical board implemented the enforcement monitor's recommendation of supporting the program administrator with two other managers but chose to create two case manager supervisor positions, rather than one case manager supervisor position and one manager position to oversee other program staff, as the enforcement monitor had recommended. In this instance, we believe the medical board should reconsider whether this choice best alleviated the problem of an overloaded program administrator.

The Current Reporting Process Does Not Provide the Medical Board With a Complete View of the Diversion Program's Performance

One of the primary ways the medical board evaluates the diversion program's performance is through reviewing quarterly reports. However, the current reporting process does not provide the medical board with a complete view of the program's operations,

The diversion program's quality review report was created to help the Division of Medical Quality answer the following questions:

- Does the diversion program protect the public?
- Are participants compliant with the diversion program's monitoring methods?
- Is the diversion program following its own procedures and doing so in a timely fashion?
- Is the diversion program effective in rehabilitating participants?

Source: Diversion task force meeting minutes from May 2000.

thus hindering its ability to provide program oversight. As required by state law, the diversion program must provide information to the Division of Medical Quality as it may prescribe to assist it in evaluating the program, directing the program's operation, or proposing changes to the program. In 1998 the Division of Medical Quality created the diversion task force to comprehensively study the diversion program; in 2000 it converted this task force to a standing diversion committee. In addition to a financial status report required by state law, the diversion committee requests that the diversion program submit quality review reports on a quarterly basis to answer the questions shown in the text box.

To answer these questions, the former diversion program administrator developed, in June 2000, a list of components that the program would include in its quality review reports. As shown in Table 4, this list included data on intakes, drug tests, diversion group attendance, case manager contacts, relapses, and successes/outcomes. Although it was not able to report on all of the components at the time, the diversion program expected to provide full reporting by fiscal year 2000–01.

Reporting on all of the components shown in Table 4 would have provided the diversion committee with a more complete view of the diversion program. However, in reviewing all of the quality review reports between June 2000 and January 2007, we found that the diversion program has never reported on four of the six originally envisioned reporting components. Specifically, the diversion program has not reported on drug tests, diversion group attendance, case manager contacts, or outcomes.

As the table indicates, the reports provide some additional information beyond what was originally envisioned. For example, starting in January 2001, the program began reporting information related to participants released from the program, whether through successful completion or termination. However, these data do not fully answer one of the four central questions of whether the program is effective in rehabilitating participants. To answer this question, the program would have needed to develop a way to determine how many graduates remain relapse-free after a certain number of years, as outlined by the former diversion program administrator in June 2000. Furthermore, none of the information added to the quality review reports, except for the length of time before the first urine test, directly measures whether the program promptly follows its own procedures.

Table 4
The Physician Diversion Program's Quality Review Reporting

REPORTING COMPONENTS ORIGINALLY ENVISIONED BY THE DIVERSION PROGRAM IN JUNE 2000	WAS THIS COMPONENT IMPLEMENTED?	ADDITIONAL INFORMATION INCLUDED IN REPORTS
Intakes Number of days between initial telephone contact and intake interview, signed interim agreement, and initial diversion evaluation committee meeting.	Yes	In June 2000 the program began reporting on the participant's current status and type of board action. It also added the number of participants not interested or ineligible for the program in December 2001 and the length of time before the participant's first urine test in April 2005.
Drug Testing Presentation and explanation of collection incident reports, action taken by program in response, timeliness of response.	No	In June 2005 the program began to include the total number of positive, negative-dilute, and invalid tests.
Diversion Group Attendance Number of unexcused absences, action taken by program in response, timeliness of response.	No	
Case Manager Contact Frequency and type of contact with participants, number of cases where minimum number of contacts are not achieved.	No	
Relapses Number of participants who relapse, how relapses are detected, action taken by program in response, timeliness of response.	Yes	In June 2000 the program provided information on the participant's current status, drug of abuse, and length of time in program. It also reported on the type of referral/enforcement activity starting in January 2001.
Outcomes Number of participants who have new disciplinary action taken by board, graduated after previously being terminated, and remained relapse free after graduating.	No	In January 2001 the program added the participant's release status, time in program at release, drug of abuse, and type of referral, whether participant relapsed, had a mental disorder, or had treatment prior to/during the program.

Sources: Quality review reports from June 2000 to January 2007 and a memorandum from the former diversion program administrator from June 2000.

The current program administrator stated that he had never seen the memorandum issued by the former program administrator in June 2000 listing the components to be included in the quality review reports. He believes that over the years, this list of reporting components was forgotten and there was no follow-up to ensure that the diversion program reported on all of them. As a result, this memorandum and the ideas within it were never passed down to him. The program administrator is currently reviewing the memorandum to determine the necessity and feasibility of implementing each reporting component.

Upon reviewing the former program administrator's list of what should be reported, the diversion committee chair (chair) stated that a number of these components could be helpful. Because she also had never seen this memorandum before, the chair explained

that she, along with the other committee members, would need to determine what measures would currently be most helpful. In addition, the committee may explore other program measures not described in this document, such as case managers' workloads.

The Diversion Program Has Not Formally Adopted and Included All of Its Policies in Its Policy Manual

Due to personnel turnover and the lack of follow-up, some policies are never fully implemented or are forgotten over time.

The diversion committee does not always ensure that policies it adopts are included in the diversion program's policy manual. As a result, due to personnel turnover and the lack of follow-up, some policies are never fully implemented or are forgotten over time. In addition, the program adheres to some policies in its daily practices that were never formalized in the policy manual. Although some program staff may be aware of these policies, adding them to the policy manual would create consistency in practice among all staff and would decrease the chance of their being forgotten in the future. Finally, although policy changes have been approved by the diversion committee in pieces, the policy manual as a whole has never been reviewed and approved by the diversion committee.

As we mentioned in Chapter 2, the Division of Medical Quality approved criteria for annual evaluations of diversion evaluation committee (DEC) members, but this policy was never added to the diversion program's policy manual. Although the former program administrator was aware of this policy and therefore conducted the evaluations, this information was never passed down to the current program administrator, who came to the program in February 2005. As a result, DEC member evaluations have not been conducted since 2003.

Likewise, as we mentioned in the previous section, the medical board and the diversion program did not implement a number of components in the quality review reports that the former program administrator envisioned. This lack of follow-up is due to the fact that policies addressing the planned components of the quality review reports were never added to the program's policy manual.

The program also has other policies that it follows in its daily activities that were never included in its policy manual. For example, as we mentioned in Chapter 2, participants must submit a vacation request to their case managers, or to their group facilitator if they will miss any group meetings, at least two weeks in advance in order to have their random drug tests rescheduled. Although this requirement is stated on the vacation request form, it is not included anywhere in the diversion program's policy manual or in

the participants' diversion agreements. Having this requirement formalized into policy would help create consistency among program staff in handling and approving vacation requests.

In addition, the program's policy manual currently states that case managers are to have regular contact with their participants. Although the policy is not specific in defining how many times per month a case manager should contact each participant, the program administrator explained that case managers should do so at least once each month. Because this is not clearly defined in the program's policies, case managers may be unaware of this standard and fail to follow it.

The chair stated that she recognizes the need for the program to formalize its policies. She indicated that the committee members have not seen all of the policies compiled as one manual and that policy changes are approved in discrete pieces. In the future, the chair stated, she would like to see the committee review and approve the policy manual as a whole and then, on an ongoing basis, ensure that approved policy changes are incorporated into the manual. She indicated that she is aware that without a process to ensure that approved policy changes are documented for the future, they can get lost, as there is turnover among the committee members and staff.

In reference to the diversion committee reviewing and approving the policy manual as a whole, the executive director of the medical board (director) explained that the policy manual includes both policy statements and detailed procedures that program staff use to implement program policy. While he believes that it is imperative that the diversion committee approve program policy, the director said that it is not efficient for the diversion committee, which is made up of physicians who essentially volunteer their time in assisting the medical board, to review and approve all the specific procedures used to carry out its policy directives. Consequently, he suggested that the program administrator and the chair identify policy statements in the manual and then have the committee review and approve these statements rather than the entire manual.

The Diversion Program Still Has Not Implemented a Number of the Enforcement Monitor's Recommendations

In spite of the diversion program's lack of progress in implementing the enforcement monitor's recommendations, the medical board has not stepped in to ensure that the recommendations are implemented in a timely manner.

As of April 2007 the diversion program had yet to fully implement a number of recommendations from the enforcement monitor's November 2005 final report. In spite of the diversion program's lack of progress in implementing these recommendations, the medical board has not stepped in to ensure that the recommendations are implemented in a timely manner. As a result, the diversion program

continues to lack development in some areas. As indicated in Table 5, the enforcement monitor provided 14 recommendations to the diversion program—eight regarding actions the program should take and six regarding actions the program should consider. Of the eight recommendations regarding actions the program should take, the diversion program has fully implemented only two. The diversion program's efforts to implement the remaining six recommendations are still in progress.

Table 5
The Physician Diversion Program's Response to the Enforcement Monitor's November 2005 Recommendations

	RECOMMENDATIONS FROM THE ENFORCEMENT MONITOR			
	THE DIVERSION PROGRAM SHOULD DO THE FOLLOWING:	IMPLEMENTED	IN PROGRESS	NOT GOING TO IMPLEMENT AT THIS TIME
1	Develop standards for work-site and hospital monitors			
2	Develop a set of consequences for relapses			
3	Evaluate the role, purpose, and structure of the liaison committee			
4	Develop protocols for communication with enforcement			
5	Update the quarterly quality review reports so they contain the most important information			
6	Review the role and duty statements of the group facilitators			
7	Develop regulations establishing qualifications and criteria for "evaluating physicians"			
8	Develop regulations governing competency examinations for program participants			

	THE DIVERSION PROGRAM SHOULD CONSIDER THE FOLLOWING:	IMPLEMENTED	IN PROGRESS	NOT GOING TO MAKE A POLICY CHANGE AT THIS TIME
1	Whether there should be a maximum participant cap			
2	Whether the program should charge practicing participants a fee to cover overhead costs			
3	The establishment of consistent criteria for termination from diversion program			
4	The establishment of a mechanism for termination and revocation of license for board-ordered and board-referred participants who continuously repeat the program			
5	Whether there should be a mandatory "practice-cessation" period for participants upon entry into program			
6	Whether the diversion program is equipped to handle mentally ill participants			

Sources: Enforcement monitor's final report, diversion committee meeting minutes, and statements from Physician Diversion Program management.

One of the two recommendations that the diversion program implemented is the review and evaluation of the role, purpose, and structure of the liaison committee. The liaison committee was originally created in 1982 to solicit suggestions, submit recommendations, and provide expertise on issues to enhance the diversion program. In February 2006 the Division of Medical Quality and the diversion committee disbanded the liaison committee with the intent of reconstituting an advisory body that would better serve the diversion program. The diversion program is now in the process of developing a diversion advisory council, which will consult on issues facing the diversion program.

One of the six recommendations the diversion program is still in the process of implementing is the development of consequences for relapses. This will include a review of the relapse referral matrix, which guides the diversion program staff in their assessment of the appropriate programmatic response for participants who have relapsed. The enforcement monitor recommended that this matrix be restated and adopted as policy. Although the diversion program has had conversations with the DEC members, group facilitators, and case managers about this issue, the program delayed the completion of the matrix so that it could be discussed at the next annual DEC meeting. As of May 2007 the program had not yet scheduled an annual DEC meeting for 2007. For its part, the medical board has not pressured the program to complete this work, even though it has been nearly two years since the recommendation was made.

In addition, although the diversion program considered all six recommendations that the enforcement monitor proposed it consider, the program has decided not to implement four of them, choosing instead to continue its current policies and practices. The diversion program has delayed its decision as to whether to implement the remaining two recommendations, as it is waiting for the establishment of the diversion advisory council, which will then meet 30 days after each board meeting to discuss these issues. As of April 2007 the diversion advisory council had not yet been formed.

According to the program administrator, it has been the diversion program that has prioritized the enforcement monitor's recommendations and established due dates for their implementation. The diversion program provides the diversion committee with written reports that describe its progress in implementing the recommendations and the due dates for the next actions to be taken. The program administrator indicated that the diversion committee has not requested or attempted to enforce the due dates described in reports to the committee.

The diversion committee has not requested or attempted to enforce the due dates described in reports to the committee.

We found that because the due dates are not being enforced, the diversion program often pushed back the dates set for implementing the recommendations. For example, for the recommendation that the program consider establishing consistent termination criteria, the initial update report to the diversion committee listed January 2006 as the date these criteria would be adopted. However, according to the program administrator, the majority of the time at the January 2006 meeting was spent providing the diversion committee with background information regarding the diversion program rather than discussing each recommendation in detail. In subsequent reports, the program listed November 2006 as the due date for establishing termination criteria because the matter was pending discussion by a subcommittee of the diversion committee. In January 2007 the due date was again delayed, this time to February 2007. The next report to the diversion committee listed the due date as April 2007. As of April 2007 this recommendation still had not been implemented.

The program administrator also stated that, in addition to the lack of pressure from the diversion committee to get recommendations implemented, the length of time the committee meets also slows the implementation of the enforcement monitor's recommendations. The diversion committee meets for only one hour each quarter to discuss the entire agenda, including quality review reports, DEC member appointments, and other outstanding issues. According to the program administrator, discussion of the enforcement monitor's recommendations has traditionally taken place at the end of these meetings, and there has not always been enough time to get the diversion committee's full input on each issue.

The recently appointed diversion committee chair indicated that she shares the concern that changes to the diversion program in response to some of the enforcement monitor's recommendations have not yet been completed.

The recently appointed chair indicated that she shares the concern that changes to the diversion program in response to some of the enforcement monitor's recommendations have not yet been completed. For instance, she stated that she is concerned that standards have not been implemented for work-site and hospital monitors, even though the committee approved them quite some time ago. In reference to the one-hour committee meetings, the chair agreed that the length of time the committee meets does, at times, affect its ability to fully discuss the enforcement monitor's recommendations. However, she pointed out that the committee members have demonstrated a willingness to attend extra meetings if warranted—as evidenced by the special sessions held shortly after the enforcement monitor published her report.

The chair also stated that she believes the slow implementation of the enforcement monitor's recommendations could be partially attributable to the fact that the same issues are discussed repeatedly. She believes that they should close down discussion of recommendations that both the diversion program and the

committee do not think should be implemented at this time and focus on the outstanding recommendations that need to be discussed and implemented. In addition, the chair believes that the committee should revisit the enforcement monitor's recommendations each year as the diversion program evolves.

The Medical Board Added Another Manager to the Diversion Program but Did So in an Area That Did Not Address the Primary Concern of the Enforcement Monitor

Rather than follow the November 2004 recommendation of the enforcement monitor to reduce the workload of the diversion program administrator by adding two managers—one to supervise the case managers and another to supervise the program support staff—the medical board provided the program administrator with two case manager supervisors. Consequently, although the program administrator received some relief from the hiring of a case manager supervisor in 2005, the addition of a second case manager supervisor at the end of 2006 did little to alleviate the scope and breadth of the duties for which he is responsible. As a result, the program administrator is not able to perform some of the policy development and program outreach he would otherwise like to perform.

Because the addition of a second case manager supervisor did little to alleviate the burden on the program administrator, he is not able to perform some of the policy development and program outreach he would otherwise like to perform.

In the November 2004 interim report, the enforcement monitor said that the diversion program administrator position was "handling supervision, program oversight, and program development—a burdensome combination of duties which one person cannot completely handle alone." She then recommended that the medical board add two managers to the program, as previously described. In the final report, published in November 2005, the enforcement monitor noted that the medical board added a case manager supervisor in February 2005 to ensure that case managers fulfill their duties. Subsequently, in July 2006, the medical board created another case manager supervisor position to oversee the three case managers in Southern California, reducing the number of case managers the existing supervisor oversees to three in Northern California.

Although this change likely eased the existing case manager supervisor's burden, we question whether it alleviated in a substantial manner the burden on the program administrator, as described by the enforcement monitor. The program administrator said that, now that the creation of a second case manager supervisor position has already taken place, he questions whether going through the process to switch the role of this manager would really be worth the effort. Although he agrees that he needs more time to focus on policy development and program outreach, the

program administrator stated that he might be able to reduce his workload by delegating more duties to staff and by creating efficient mechanisms to oversee staff, as we have suggested. He further explained that, in fact, he will be delegating a number of duties to the two case manager supervisors. For example, he plans on having them evaluate group facilitators and also represent program management at many of the DEC meetings. He believes that this last task in particular will allow him the time for many of the other activities, such as program outreach, that he has wanted to perform.

Although we still believe that the organizational structure outlined by the enforcement monitor would have provided greater relief to the program administrator's workload, we can appreciate the argument that a second case manager supervisor position has already been approved and an individual has already been selected and hired. To the extent that the program administrator can delegate tasks to these supervisors, such as attendance at DEC meetings, he should be able to focus on improving the program's policy development and oversight mechanisms, reporting to the diversion committee, and performing program outreach. We encourage the medical board to ensure that its diversion program administrator does so.

Recommendations

To effectively oversee the diversion program, the medical board should require the program to create a reporting process that allows the medical board to view each critical component of the program.

To the extent that the diversion program lacks the data required to report on the performance of critical components of the program, the medical board should require program management to develop mechanisms to efficiently acquire such data so that both the medical board and program management can provide effective oversight.

To ensure that it adequately oversees the diversion program, the medical board should have its diversion committee review, clarify where necessary, and approve all policy statements contained in the program's policy manual. Any informal policies that the program is currently operating under, but that are not in the policy manual, should be reviewed and approved by the diversion committee. Finally, the diversion committee should ensure that any policy directive it approves is added promptly to the manual.

The medical board should ensure that areas of program improvement recommended by the enforcement monitor are completed within the next six months. If necessary, the diversion committee should meet for longer than one hour each quarter until this is accomplished.

The medical board should direct the program administrator to delegate some of his day-to-day tasks so that he can refocus his efforts on program development. To the extent that delegation alone is not sufficient to accomplish this goal, the medical board should reconsider its decision to have two case manager supervisors rather than one case manager supervisor and one supervisor of other program staff.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of the report.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE
State Auditor

Date: June 7, 2007

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Appendix

THE PHYSICIAN DIVERSION PROGRAM HAS MADE IMPROVEMENTS SINCE THE FINAL ENFORCEMENT MONITOR REPORT

As we discussed in the Introduction, the enforcement monitor was appointed to review the Physician Diversion Program (diversion program) of the Medical Board of California (medical board). The enforcement monitor issued two reports—an interim report in November 2004 and a final report in November 2005. As indicated in Table A on the following pages, the diversion program began addressing some of the enforcement monitor's concerns prior to the issuance of the final report and has made additional progress since then. However, we also noted that the diversion program has not yet responded to some enforcement monitor concerns, and these areas continue to be deficient.

Table A

Progress Made by the Physician Diversion Program Since the Issuance of the Enforcement Monitor's Reports

FUNCTIONAL AREA OF DIVERSION PROGRAM (ATTRIBUTE)	KEY STATISTICS AND FINDINGS FROM THE ENFORCEMENT MONITOR		KEY FINDINGS FROM OUR REVIEW	PROGRESS SINCE ENFORCEMENT MONITOR'S REPORTS
	NOVEMBER 2004 INITIAL REPORT	NOVEMBER 2005 FINAL REPORT		
Staffing	The program administrator position in the diversion program is overloaded; the position should be supported by a case manager supervisor and a supervisor of other staff and functions.	In February 2005 the medical board hired a case manager supervisor.	As indicated in Figure 3 in the Introduction, the medical board has hired a second case manager supervisor. However, as discussed in Chapter 3, this administrative structure has not sufficiently relieved the burden on the program administrator.	The diversion program has improved in this area, but deficiencies still exist.
Staffing	The program's five case managers are so overloaded that all they are able to do is react to relapses; case managers should have no more than 50 cases each.	The medical board submitted a budget change proposal for additional case managers and the conversion of a seasonal clerk position to full-time.	As indicated in the Introduction, the diversion program now has six case managers. According to case manager reports, average caseloads have decreased from 53 in November 2005 to 37 in March 2007.	This issue has been addressed.
Staffing	The collection system manager position is significantly understaffed.	In March 2005 the program expanded its existing collection system manager position to a full-time position devoted almost entirely to overseeing drug tests.	Nothing additional to report.	This issue has been addressed.
Case managers (reporting)	Program management allowed two of the program's five case managers to file very few monthly reports between January 2003 and August 2004.	The new case manager supervisor now requires and reviews case managers' monthly reports.	Between November 2005 and October 2006, all case manager reports were submitted as required.	This issue has been addressed.
Drug testing (timeliness)	Twenty-five percent of new participants are not scheduled for any drug tests within one month of their intake interview.	No additional findings or information provided in the final report.	18 percent of the new participants in 2005 and 2006 from our sample did not receive a drug test within one month of their intake interview. As indicated in Chapter 1, the program has dramatically decreased the length of time to perform the first drug test, but does not appear to have met its goal of seven days or less.	The diversion program has improved in this area, but deficiencies still exist.
Drug testing (timeliness)	Out of 20 relapses reviewed, four participants' drug tests were not resumed within one month following completion of treatment.	No additional findings or information provided in the final report.	The program no longer follows the same process as was reported in the enforcement monitor's report. Participants remain on the drug testing calendar while in treatment. Drug tests resume following completion of treatment according to the dates assigned on the randomly generated calendar.	This issue has been addressed.
Drug testing (randomness)	Only 40 percent of a sample of drug tests were completed as scheduled.	No additional findings or information provided in the final report.	74 percent of scheduled drug tests in June and October 2006 were completed on their randomly scheduled dates.	The diversion program has improved in this area, but deficiencies still exist.
Drug testing (randomness)	The program does not make the effort to track actual collections to ensure that participants receive the required number of drug tests and that the tests occur on their randomly scheduled date.	The program requires monthly reports from the collectors that document that tests have been administered on the scheduled dates. The collection system manager manually verifies that participants are given the required number of tests each month.	The program now reconciles collection reports with actual drug tests. However, as we point out in Chapter 2, this reconciliation process has significant weaknesses that must be improved.	The diversion program has improved in this area, but deficiencies still exist.

FUNCTIONAL AREA OF DIVERSION PROGRAM (ATTRIBUTE)	KEY STATISTICS AND FINDINGS FROM THE ENFORCEMENT MONITOR			
	NOVEMBER 2004 INITIAL REPORT	NOVEMBER 2005 FINAL REPORT	KEY FINDINGS FROM OUR REVIEW	PROGRESS SINCE ENFORCEMENT MONITOR'S REPORTS
Drug testing (reporting)	Out of 20 relapses reviewed, the results from four positive drug tests were not reported in time frames ranging from 10 to 14 days and another was not reported for at least three weeks.	No additional findings or information provided in the final report.	As indicated in Chapter 1, out of the 43 positive or negative-dilute tests we reviewed, the results from 10 were not reported within seven days.	The diversion program has improved in this area, but deficiencies still exist.
Drug testing (recording)	The program does not ensure that test results are actually received from the laboratory and downloaded into the Diversion Tracking System (DTS), leading to gaps in the participants' collection records. In addition, more than 300 lab reports received during the testing period did not contain a donor ID and therefore had not been appended to the appropriate participant's record in the DTS.	The medical board's information systems branch created a new DTS whereby urine test results forwarded by the lab are automatically downloaded into the DTS and appended to the participant's DTS file. The collection system manager conducts spot checks for accuracy.	All of our sampled participants' urine test results were automatically downloaded into DTS and no gaps in their collection records were found. However, we found some instances where errors in the recording of participants' donor IDs or collection dates led to inaccuracies in the drug test results.	The diversion program has improved in this area, but deficiencies still exist.
Collectors (evaluation of performance by program)	Deviations from the drug test schedule appear to be tolerated with no discussion or sanction.	The program terminated several collectors who would not adhere to the random schedule and other program requirements.	As indicated in Chapter 2, the program does not document instances when collectors do not adequately perform their duties and has not developed an evaluation mechanism for its collectors.	The diversion program has not adequately addressed this area.
Collectors (reporting)	Only five of the 30 required collector reports were received for December 2003.	No additional findings or information provided in the final report.	23 of the 25 required collector reports were received in October 2006. Missing reports received adequate follow-up.	This issue has been addressed.
Work-site monitors (policy)	The program has not set forth a work site definition of the duties or qualifications of a work-site monitor.	The diversion committee has not yet established meaningful standards for work-site monitors but the program has instituted a new policy that it will no longer approve increases in participant's work hours, or reductions in drug tests, if a participant is not in compliance with work-site monitoring requirements.	As indicated in Chapters 1 and 3, the board's expectations for work-site monitors have been developed but have not been approved or fully implemented. In addition, the current manual does not contain the new policy on increases in participants' work hours or reductions in drug tests, and we did not see evidence of this practice in our review.	The diversion program has not adequately addressed this area.
Work-site monitors (reporting)	Only seven of a sample of 20 participants had a complete or nearly complete set of quarterly work-site monitor reports in their file.	Program staff are working with the medical board's information technology unit to develop a mechanism to identify participants not in compliance with the work-site monitoring requirements.	Fifteen of the 18 physicians in our sample who required work-site monitoring reports during the period of our review had a complete or nearly complete set of reports in their file. However, as we point out in Chapter 1, there are a number of improvements the diversion program still needs to make in this area.	The diversion program has improved in this area, but deficiencies still exist.

continued on the next page

FUNCTIONAL AREA OF DIVERSION PROGRAM (ATTRIBUTE)	KEY STATISTICS AND FINDINGS FROM THE ENFORCEMENT MONITOR		KEY FINDINGS FROM OUR REVIEW	PROGRESS SINCE ENFORCEMENT MONITOR'S REPORTS
	NOVEMBER 2004 INITIAL REPORT	NOVEMBER 2005 FINAL REPORT		
therapists (reporting)	None of the 18 participants reviewed had a complete, or nearly complete, set of therapist reports in their file.	The new case manager supervisor is beginning to address this issue with case managers and the program has instituted a new policy that will no longer approve increases in participant's work hours or reductions in drug tests if a participant is not in compliance with therapist reporting requirements.	Six of the 18 physicians in our sample who required therapist reports during the period of our review had a complete, or nearly complete, set of reports in their file. As noted in Chapter 1, the current manual does not contain the new policy on increases in participants' work hours or reductions in drug tests and we saw no evidence in our review that this practice is followed.	The diversion program has improved in this area, but deficiencies still exist.
Diversion evaluation committee (policy)	Diversion evaluation committees (DECs) operate without any written standards that would help ensure that recommendations are fair, consistent, and protective of the public. For instance, there is no consistently applied and enforceable rule regarding consequences for relapse.	The diversion program undertook an overhaul of its manual. The new manual needs to be reviewed by legal counsel, the diversion committee, and the Division of Medical Quality.	The diversion program added a chapter on diversion evaluation committees to its policy manual outlining the role of the DEC and standards for its recommendations. Discussions were held with DEC members, group facilitators, and case managers regarding the consequences for relapse.	The diversion program has improved in this area, but deficiencies still exist.

Sources: Auditor analysis of information obtained from enforcement monitor's initial and final reports and our review of the Physician Diversion Program.

(Agency response provided as text only.)

State and Consumer Services Agency
915 Capitol Mall, Suite 200
Sacramento, CA 95814

May 30, 2007

Ms. Elaine Howle, State Auditor*
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle,

Thank you for giving me the opportunity to respond to your audit addressing the Medical Board of California. I understand that your audit sample included physicians from between November 2005 and October 2006.

In preparing for my confirmation as Agency Secretary in February 2007, I committed to implement recommendations from the Bureau of State Audits. I have directed the Department of Consumer Affairs' new director Carrie Lopez to follow though on your audit recommendations to the Medical Board. Her specific comments are attached.

I have directed the Medical Board to send a six month and one year update on their efforts through the Department of Consumer Affairs. I recognize your recommendations as an opportunity to improve the Medical Board and truly appreciate your support of the Department of Consumer Affairs' goals of protecting California's consumers.

Most Sincerely,

(Signed by: Rosario Marín)

Rosario Marín, Secretary
State and Consumer Services Agency

*California State Auditor's comments appear on page 81.

(Agency response provided as text only.)

Department of Consumer Affairs
1625 North Market Blvd., S308
Sacramento, CA 95834

May 25, 2007

In reply to: Medical Board of California's Physician Diversion Program Audit

Elaine M. Howle
State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

At the direction of Secretary of State and Consumer Services Agency Secretary Rosario Marin, I am responding to the Bureau of State Audit's findings on the Department of Consumer Affairs' (Department) Medical Board of California (Board), Physician Diversion Program.

It is my understanding that the Board is currently drafting its response and developing an implementation plan for addressing the concerns identified in the audit. It is also my understanding that SB 761 (Ridley-Thomas) is a placeholder bill to address any shortcomings in the diversion program.

The Department's responses to the audit recommendations are listed below.

1. To better monitor diversion program participants, program management should create mechanisms to ensure that group facilitators, therapists, and worksite monitors submit required reports, and that the participants submit required meeting verifications. *The Department concurs with this recommendation. Action: We will work with the Board to review their current technology infrastructure and recommend program improvements where necessary.*

2. To ensure a timely and adequate response to positive drug tests or other indications of a relapse, the diversion program should do the following:

   - Immediately remove practicing physicians from work when notified of a positive drug test.

   - Require diversion evaluation committees (DECs) to provide justification when they determine that a positive drug test does not constitute a relapse.

   - Have a qualified medical review officer evaluate all disputed drug test results if its new advisory committee determines that this action is needed.

The Department concurs with this recommendation. Action: We will encourage the Board to seek Interim Suspension Orders when appropriate, through the Office of the Attorney General and support their efforts in seeking such orders.

3. The diversion program should ensure that both the case manager and group facilitator approve all vacation requests and should establish a more timely and effective reconciliation of scheduled drug tests to actual drug tests performed by comparing the calendar of randomly generated assinged dates to the lab results. *The Department concurs with this recommendation. Action: None.*

4. To ensure that it adequately oversees its collectors, group facilitators, and the DEC members, the diversion program should formally evalutate the performance of these individuals annually. *The Department concurs with this recommendation. Action: We will assist and facilitate the Board's efforts in obtaining a Budget Change Proposal (BCP) should it be determined that a BCP is necessary to implement this recommendation.*

5. To effectively oversee the diversion program, the Board should require it to create a reporting process that allows the Board to view each critical component of the program. *The Department concurs with this recommendation. Action: None.*

6. To ensure that it adequately oversees the diversion program, the Board should have its diversion committee review and approve the program's policy manual. Thereafter, the diversion committee should ensure that any policy change it approves is added to the manual. *The Department concurs with this recommendation. Action: None.*

7. The Board should ensure that areas of program improvement recommended by the enforcement monitor are completed within six months. *The Department concurs with this recommendation. Action: If a BCP is necessary to fulfill this recommendation, we will work with the Board to ensure its timely completion.*

The Department will actively encourage the Board to send you a six-month and one-year status reports on its progress with respect to the implementation of the audit recommendations.

Thank you for giving me the opportunity to respond to your audit report. Please feel free to contact me at (916) 574-8200 should you have any questions. Thank you.

Sincerely,

(Signed by: Carrie Lopez)

CARRIE LOPEZ, Director
Department of Consumer Affairs

(Agency response provided as text only.)

Medical Board of California
1434 Howe Avenue, Suite 92
Sacramento, CA 95825-3236

May 29, 2007

Elaine M. Howle
California State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

RE: Draft Audit Report – Medical Board of California's Physician Diversion Program

Dear Ms. Howle:

The Medical Board of California (Board) is in receipt of your draft audit report for the board's Physician Diversion Program. Thank you for allowing the board to respond to the issues and concerns raised in the report. Enclosed please find our responses to each recommendation.

The board would like to thank the Bureau of State Audits for conducting this audit. Several of the Diversion Program's processes have been improved, based upon the findings during the auditor's review. Several of the recommended changes already have been implemented, even before the audit was completed. Other changes are in process and should be finalized in the very near future.

We are gratified that the auditor recognizes the many programmatic improvements made over the past two years, including: a new, real time, Diversion Tracking System; a far superior method of managing and controlling the collection of urine samples from participants, including a full-time collection system manager; the addition of two new case manager supervisors; the lowering of case manager caseloads to an acceptable level by adding additional case managers to the program; the elimination of the Diversion Liaison Committee (which was largely ineffective) and replacing it with a new Diversion Advisory Council which answers to the Board's Diversion Committee; and the implementation of policies and procedures to ensure the program will operate in a manner that provides maximum public protection.

The Board is committed to implementing the State Auditor's recommendations and believes these will enhance the public protection improvements already made to the Program. We invite the State Auditor to conduct follow-up reviews at six-months and one-year to ensure the Board has followed through and implemented the recommendations contained in the report.

If you have any questions regarding this response, please contact me at (916) 263-2389.

Sincerely,

(Signed by: Dave Thornton)

Dave Thornton
Executive Director

Medical Board of California
Response to Recommendations of Bureau of State Audits
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Chapter 1 Recommendations

Recommendation: To better monitor diversion program participants, program management should create mechanisms to ensure that group facilitators, therapists, and worksite monitors submit required reports, and that the participants submit required meeting verifications. When such documentation is not received, program management should have case managers make an effort to obtain this information.

Response: The Medical Board (Board) concurs with this recommendation. The Board has been working to finalize written policies and procedures for the entire Diversion Program. These policies and procedures are awaiting final review and approval by the Board's legal counsel. The policies and procedures will include direction to all parties to ensure required documentation is provided to the Program. The policies and procedures will not only inform the reporting party of their requirement to provide written verification/ documentation, but also will provide direction to the case manager as to his/her responsibility to update the Diversion Tracking System (DTS) and the participant's file. The policies and procedures also will require the case manager supervisor to conduct follow-up on compliance by case managers for each participant's required documentation by all pertinent parties.

Moreover, the Board will be looking into the feasibility of having all documentation for a participant's file scanned into the DTS so it is documented and readily available for all staff to review. Reports could be generated from the scanned documents indicating whether they have been received. This will greatly assist both the case managers in follow-up of their cases as well as provide the case manager-supervisor II the necessary tools to oversee the work of the case managers.

Recommendation: The Diversion Program should institute a formal policy to increase or refuse to reduce the frequency of diversion and support group meetings and drug tests when a participant neglects to provide required documentation. In addition, the program's policy should include a provision to not lift or reduce work restrictions unless a participant is in full compliance with worksite monitoring requirements.

Response: The Board concurs with this recommendation. The new policies and procedures mentioned above have established a minimum period of compliance with agreement requirements before any changes in a participant's contract will be allowed. No reductions in any participant's agreement (including work restrictions) will be considered if the individual is not in full compliance with his/her agreement (including documentation requirements).

These new policies and procedures will state that a reduction in group meetings will not be considered unless the participant has completed at least three years in the Diversion Program and is in full compliance with his/her agreement. All such requests must be approved by the Diversion Evaluation Committee (DEC) or a DEC consultant.

Reductions in drug screens will require the participant to: 1) be in full compliance with his/her agreement and 2) have no relapses for three years. This request by a participant must also be approved by the DEC or a DEC consultant.

It will be the responsibility of the Program Administrator, in conjunction with the DPCS II, to ensure that these policies are adhered to by case managers and the DEC. All case managers were recently reminded of these requirements.

Recommendation: To eliminate uncertainty regarding individual participants' requirements, the program should process a formal amendment to a participant's diversion agreement if the program determines that a requirement should be changed for that physician.

Response: The Board concurs with this recommendation. The new policies and procedures will include the requirement that any change in requirements will be in the form of a written formal amendment to the participant's agreement. This procedure has been provided to case managers.

Recommendation: To ensure that worksite monitors provide unbiased and complete reports, the diversion program should do the following:

- Ensure that each participant's worksite monitor is approved in advance and has no relationship with the participant that would impair his or her ability to render fair and unbiased monitoring reports.

- Ensure that the newly developed worksite monitor agreements containing conflict-of-interest language are approved by the medical board's executive office and signed by all worksite monitors.

- Notify worksite monitors of any work restrictions imposed on the participant they are monitoring, and direct them to report on compliance with these requirements.

Response: The Board concurs with this recommendation. The Diversion Program staff began drafting worksite monitor policies after the release of the enforcement monitor's report. The Diversion Committee approved the draft worksite monitor policy changes in July 2006, however they have not been finalized and implemented. Since these policies were in the drafting process while this audit was being conducted, the auditor's early recommendations also were discussed and included in the draft policies and procedures. The new Diversion Program policies and procedures include the requirements for the worksite monitors as well as instruction to the case managers in outlining what is required for a worksite monitor. The case managers have been given the new requirements and agreements and have been reminded of the importance of compliance with the new worksite monitor policies.

All new potential worksite monitors will be met, in person, by the case manager. The case manager will go over the Agreement to Monitor, which includes the conflict-of-interest information. The monitor's roles and responsibilities will be discussed with the monitor to ensure he/she knows his/her role. Program staff intends that by July 1, 2007 all existing worksite monitors will be provided with the new agreement form and will have signed this new form. Case managers will meet with the existing monitors as well, to discuss the changes. All new worksite monitors will receive the new agreement. The Program will determine if any current worksite monitors have a conflict-of-interest with their participants and take appropriate action, if necessary, to resolve the situation.

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Additionally, case managers have begun to, and will continue to, contact worksite monitors when changes occur with a participant's work restrictions. The monitor also will be provided a copy of the participant's new agreement with the amendment which may affect the participant's work.

Recommendation: To ensure that participants receive program services on a timely basis, the diversion program should continue its efforts to achieve the goal of completing participants' first drug tests within seven days of their intake interview.

Response: As pointed out by the auditor the Program has dramatically improved the time it takes to do the first drug test from 35 days in 2004/2005 to 18 days in 2005/2006 and will continue to work to improve its processes to meet the seven-day goal. At the April 26, 2007 Diversion Committee Meeting, it was reported that the average during the second quarter of fiscal year 2006/2007 was five and one half days from the initial interview to the first drug test. Additionally, the Program is considering requiring the first drug test at the time of the intake interview.

Recommendation: To ensure timely and adequate response to positive drug tests or other indications of a relapse, the diversion program should do the following:

- Immediately remove practicing physicians from work upon receiving notice of a positive drug test.
- Provide sufficient justification when it determines that a positive drug test does not constitute a relapse.
- Have the reconstituted liaison committee assess the need to have an MRO [medical review officer] evaluate disputed drug test results, and hire such an individual if it is determined that this action is needed.

Response: The Board concurs with this recommendation. The Board feels strongly that there should be zero tolerance when a positive drug test is received. It is the Program's policy to remove a physician from practicing immediately upon notification of a positive drug test; however, as in any program, mistakes or errors in judgment can be made. Due to the seriousness of this recommendation, the Program Administrator will endeavor to ensure that every positive outcome results in the removal of the physician from practicing until further analysis and research can be completed. The Program will develop a method whereby the Program Administrator is notified of every positive drug test, so that he/she can follow-up on the action taken or assist in determining any change in the action to be taken.

Additionally, it will be required that every positive drug test, where it is determined that a relapse did not occur, be justified in writing and this justification will be placed in the participant's file.

The Board will ask the DAC to assess the need for an MRO. If this position to perform an assessment is still needed, then the Board will move forward to hire an MRO to evaluate disputed drug tests.

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Chapter 2 Recommendations

Recommendation: To ensure that it adequately oversees participants' random drug tests, the diversion program should do the following:

- Change existing policy to require both the case manager and the group facilitator to approve all vacation requests prior to the rescheduling of any drug tests.

- Establish a control over the rescheduling of drug tests that prohibits the collection system manager from rescheduling drug tests without a properly approved vacation request and also prevents participants from submitting vacation requests directly to the collection system manager.

- Clarify the vacation request policy for participants, and incorporate the 14-day notice requirement for vacation requests into the participants' diversion agreements.

- Establish a more timely and effective reconciliation of scheduled drug tests to actual drug tests performed by comparing the calendar of randomly generated assigned dates to the lab results.

- Require a program manager to review the drug test reconciliation to ensure that it is complete and accurate.

Response: The Board concurs with these recommendations. In regards to vacation requests, the new policies and procedures have been amended to reflect these recommendations. Specifically, the procedure has been changed so that both the group facilitator and the case manager will approve and sign all vacation requests. If a request is sent to the Collection System Manager without the case manager's approval, DTS is checked to see if the request has been noted as approved. If there is no notation in DTS, an email is sent to the case manager to verify that the request has been approved. Only after the case manager notifies the Collection System Manager that the request has been approved, are the collection dates changed to accommodate the request. Lastly, the Program will amend the Diversion Participant Agreement to include the 14-day notice requirement for vacation requests. This has been the policy, but it has not been specified in the agreement so the participant is not fully aware of this requirement in writing at the beginning of his/her enrollment.

Regarding the timely reconciliation of scheduled drug tests, the Program now will reconcile the lab results to the scheduled test twice a month using the calendar and the collectors' collection report and ensure any missed scheduled test will be rescheduled. Further, the Collection System Manager will follow-up with the collector and verify that the proper documentation has been received and provided to the case manager (and other staff as necessary) for further follow-up. Additionally, the Collection System Manager will provide the Program Manager with a bi-monthly summary of the reconciliation of the lab results and scheduled test to ensure the reconciliation is done timely and issues are discovered and addressed quickly.

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Recommendation: To ensure that it adequately oversees its collectors, group facilitators, and DEC members, the diversion program should do the following:

- Document instances in which the collector moves drug test dates without receiving approval two weeks in advance, makes an error in the submission of a urine sample, or fails to file an incident report when required. In these instances, the collection system manager should contact the collector, determine the cause of the noncompliance and reiterate the need to follow program policy if necessary.

- Maintain updated files on group facilitators to ensure that they stay current with required licenses, certifications, and continuing education requirements.

- Formally evaluate collectors, group facilitators, and DEC members annually and take timely corrective action when these individuals do not fulfill their responsibilities.

Response: The Board concurs with these recommendations. As previously stated, the Program has developed new policies and procedures for all persons involved in the Diversion Program, including collectors, group facilitators, case managers, worksite monitors, and DEC members. These policies and procedures will indicate each person's responsibility in the diversion monitoring process. When any new person starts with the Program, he/she will be provided with these policies and procedures and discussions will take place with this person to ensure he/she understands his/her role.

On February 11, 2006 and May 11, 2007, the Program held refresher/training courses to ensure collectors are adequately trained on the policies and procedures related to urine collections. The Program will continue to provide yearly refresher/training courses and conduct individual annual evaluations for current collectors. The evaluation will consist of a written evaluation and discussion of the service provided during the past year. The collectors will sign a contract containing terms and conditions to continue providing services for the upcoming year. The evaluations and contracts will be done yearly.

New collectors will sign a contract containing terms and conditions regarding providing services during the first year and will be closely monitored for the first 30 days to ensure that policies and procedures are being followed. A 30-day evaluation will be conducted that consists of a written evaluation and discussion of the service provided over the past 30 days. If the evaluation is favorable and the Program allows the collector to continue providing services, evaluations and contracts will be done annually as indicated above.

As evidence that these new procedures are providing adequate tools to ensure the Program hires quality collectors, two newly hired collectors were recently terminated within the first 30 days because their performance did not warrant their continued service.

Program staff will conduct an annual review of all group facilitators. This review will include checking the status of their licenses/certifications and ensuring they are in compliance with continuing education requirements. Meetings were held with the group facilitators to discuss the new policies and procedures. New agreements have been drafted and signed by existing group facilitators. In addition to other requirements, the new agreement states the facilitator must notify the Program of any criminal or

administrative action pending against them or their license/certificate. On an annual basis, the group facilitator will be evaluated by the case manager, the DPCS II, the Program Administrator, and the DEC members.

The Board is aware that the DEC members have not been evaluated for some time. However, based upon discussion with the auditors, the Program Administrator began an evaluation process for the DEC members. This evaluation will be completed by other DEC members, group facilitators, and case managers. Evaluation forms were sent to all parties and have been received back by the Program. These evaluations will be reviewed and any necessary action will be taken. This evaluation process will be placed into the policies and procedures and will be conducted on an annual basis.

Failure to comply with the policies and procedures by any person involved in the monitoring process will be discussed with that individual and continued noncompliance will lead to termination of duties.

Chapter 3 Recommendations

Recommendation: To effectively oversee the diversion program, the medical board should require the program to create a reporting process that allows the medical board to view each critical component of the program.

To the extent that the diversion program lacks the data required to report on the performance of critical components of the program, the medical board should require program management to develop mechanisms to efficiently acquire such data so that both the medical board and program management can provide effective oversight.

Response: The Board concurs with these recommendations. The Program has added several elements to its Quarterly Review Reports. However, the Diversion Committee will meet to review the recommendations from June 2000 (as mentioned in the audit report) and determine what elements it believes should be in a report from the Program to the Committee. Once these determinations are made, reports will be set up within the DTS to assist in obtaining the necessary information.

Recommendation: To ensure that it adequately oversees the diversion program, the medical board should have its diversion committee review, clarify where necessary, and approve all policy statements contained in the program's policy manual. Any informal policies that the program is operating under, but that are not in the policy manual, should be reviewed and approved by the diversion committee. Finally, the diversion committee should ensure that any policy directive it approves is added promptly to the manual.

Response: The Board concurs with this recommendation. As stated in the first response above, Program staff is in the final stages of putting together a policies and procedures manual. All policies within the manual will be reviewed by the full Diversion Committee. Changes requested by the members will be incorporated into the policies and procedures. Once this final version has been completed, any future amendments will be tracked by revision date and revision number. Additionally, any future policies approved by the Diversion Committee will be added to the Program's policies and procedures prior to the next Diversion Committee meeting. Follow-up of this requirement will be performed by the Program Administrator, the Deputy Director, and the Executive Director.

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Recommendations: The Medical Board should ensure that areas of program improvement recommended by the enforcement monitor are completed within the next six months. If necessary, the diversion committee should meet for longer than one hour each quarter until this is accomplished.

Response: The Board concurs with this recommendation. The Diversion Committee has had several meetings to discuss the Enforcement Monitor's report at length. Based upon these meetings, determinations were made that some of the issues/recommendations of the monitor will not be implemented or discussed further. At the April 26, 2007 Diversion Committee meeting other issues were referred to the DAC for review and consideration. The Board intends that the Program and the Committee meet this recommendation and finalize its review and discussion of all the recommendations within six months. ①

Recommendation: The medical board should direct the program administrator to delegate some of his day-to-day tasks so that he can refocus his efforts on program development. To the extent that delegation alone is not sufficient to accomplish this goal, the medical board should reconsider its decision to have two case manager supervisors, rather than one case manager supervisor and one supervisor of other program staff.

Response: The Board concurs with the delegation of some of the day-to-day tasks from the program administrator. Based upon this recommendation, the Board will be putting forward a budget change proposal requesting a supervisor for the administrative staff of the Program. This will allow the Board to continue to maintain two case manager supervisors and have a supervisor over the support staff. ②

The addition of another case manager supervisor was a decision that the program administrator and the executive staff believe is necessary for several reasons. The case managers are located statewide. The case managers are the individuals responsible for monitoring participants, which is a time-consuming task. In addition to ensuring that the participant is doing everything required in his/her agreement and following up on positive drug tests, they also need to ensure that the group facilitators and worksite monitors are completing their role in the diversion monitoring process (including ensuring documentation is received for all processes). The case manager attends group meetings and DEC meetings. The supervisor is responsible for ensuring that the case managers are performing all of these duties. To do this, the supervisor must also attend group facilitator meetings and DEC meetings as well as meetings with case managers to go over their caseloads.

For one individual to perform this duty statewide is not logical. The travel time did not allow this individual to meet with all case managers and attend group facilitator meetings and DEC meetings as needed. Therefore, the Program Administrator also was attending group facilitator meetings and DEC meetings regularly, which required considerable travel time. In an attempt to provide better oversight, another case manager supervisor was hired. This second supervisor has been able to hold the case managers accountable for their duties and attend necessary meetings. In addition, supervisors have a small caseload of their own, which assists in being aware of the issues of the case managers. This has and will continue to assist the program in ensuring compliance by all involved in the diversion process.

By having two case manager supervisors and requesting a supervisor for the support staff, the Program Administrator will have more time to focus on his responsibilities in accessing the overall compliance of the program with its statutory mandate of public protection.

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Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE MEDICAL BOARD OF CALIFORNIA

To provide clarity and perspective, we are commenting on the response to our audit from the Medical Board of California (medical board). The numbers correspond with the numbers we have placed in the department's response.

We appreciate that the medical board can choose not to implement all of the enforcement monitor's recommendations. However, for those it intends to implement, we are recommending that the medical board ensure that the recommendations be completed in the next six months, not just reviewed and discussed. ①

To clarify, our recommendation was not that the medical board add a third supervisory position to the Physician Diversion Program (diversion program). Rather, we recommended that the medical board direct the diversion program administrator to delegate some of his day-to-day tasks so that he can refocus his efforts on program development. To the extent that delegation alone does not accomplish this goal, we recommended that the medical board reconsider its decision to have two case manager supervisors, rather than one case manager supervisor and one supervisor of other program staff. ②

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State
Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analys
Senate Office of Research
California Research Bureau
Capitol Press

Report to the Legislature

Vertical Enforcement

July 19, 2007

Medical Board of California

Report to the Legislature
Vertical Enforcement

July 19, 2007

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Executive Summary

The Legislature has declared that, "by ensuring the quality and safety of medical care... [the Medical Board of California (MBC)] performs one of the most critical functions of state government." (Gov. Code, § 12529.6, subd. (a)) The MBC has been in existence since 1876. Its mission is to protect healthcare consumers through the vigorous, objective enforcement of the Medical Practice Act.

Over the years, the Legislature has periodically reviewed the MBC's performance and taken important steps to refine its operations to further improve public protection. ***(Refer to Appendix A for detailed history)***. Notably, in 1990, major reforms were initiated by SB 2375 (Presley, ch. 1597, Statutes of 1990), including the establishment of the Health Quality Enforcement Section (HQES) of the Department of Justice (DOJ). In so doing, the Legislature consistently has sought to bring investigators and prosecutors together to investigate allegations of misconduct by physicians and surgeons. During the 2005-2006 session, the Legislature took yet another important step in this process by directing the MBC and HQES to implement the "vertical prosecution model" (herein referred to as vertical enforcement or VE) for such investigations (SB 231 (2005 Reg. Sess.), § 28). The legislative goal of this two-year VE pilot is to bring MBC investigators and HQES deputy attorneys general together from the beginning of an investigation with the goal of increasing public protection by improving coordination and teamwork, increasing efficiency, and reducing investigative completion delays.

The MBC and HQES have worked closely to implement the VE model. The statistical data collected by the MBC during the first 16 months of the VE pilot shows, when modified to exclude cases prior to implementation of the pilot, an overall decrease of 10 days in the average time to complete an investigation. This decrease is even more significant when consideration is given to fact that the MBC has continued to operate without sufficient investigator staffing and, while it was working to implement the VE model, MBC investigators were saddled with over 1,000 pending pre-2006 investigations.

While data is limited, the VE pilot shows significant promise in the following areas:

1. Cases Closed Without Prosecution – The average number of days to close pre-VE cases was 145 days; after VE, it was reduced to 139 days.

2. Obtaining Medical Records – Prior to the VE pilot, it took an average of 74 days to obtain medical records; after VE, it was reduced to 36 days.

3. Obtaining Physician Interviews – Prior to the VE pilot, the average time between the initial request for an interview and the actual interview was 60 days; after VE, it was reduced to 40 days.

4. Obtaining Medical Expert Opinions – Prior to the VE pilot, the average number of days to obtain a medical expert opinion was 69 days; after VE, it was reduced to 36 days.

5. Obtaining HQES Filing – Prior to the VE pilot, the average number of days from investigative completion to the filing of an accusation was 241 days; after VE, it was reduced to 212 days.

6. Interim Suspension Order (ISO) or Temporary Restraining Order (TRO) – Prior to the VE pilot, it took 91 days from the receipt of the investigation to the granting of an ISO or TRO; after VE, it was reduced to 30 days.

Reducing investigative completion delays, however, is only one method of measuring improved public protection. The VE pilot was implemented by the Legislature in recognition of "...the critical importance of the board's public health and safety function, the complexity of cases involving alleged misconduct by physicians and surgeons," [and because of] "...the evidentiary burden in the board's disciplinary cases . . ." (Gov. Code, §12529.6, subd. (a).) While difficult to objectively measure through statistics, improving coordination and teamwork between investigators and prosecutors significantly improves the quality of the investigation of these complex cases. Implementation of the VE pilot mandated by SB 231 has resulted in improvement in all of these areas. Additional efficiencies may be gained by revising the VE program.

During much of the 2005 legislative process, SB 231 contained provisions that provided for the transfer of MBC investigators to the DOJ, with the goal of creating a pure VE model where investigators and prosecutors were employed by the same agency, and worked together under a single chain-of-command in a common location. Ultimately, however, the Legislature elected not to take this final step and, instead, established VE as a two-year pilot with investigators continuing to be employed by the MBC. The decision not to transfer MBC investigators to the DOJ has presented significant challenges to both agencies as they have worked together to implement the VE pilot. It also has resulted in the loss of experienced MBC investigators who, uncertain over their careers, have elected to seek employment with other law enforcement agencies offering higher salaries and lower caseloads of lesser complexity. Thus, while the VE pilot has demonstrated preliminary benefits, the cost of continuing this program in its current configuration ultimately may undermine the very public protection goals it was originally enacted to achieve.

As part of SB 231, the Legislature directed the MBC, in consultation with the Departments of Justice, Consumer Affairs, Finance, and Personnel Administration, to make recommendations to the Governor and Legislature on the VE pilot established by the bill. (Gov. Code, § 12529.7.) Pursuant to that legislative mandate, the MBC submits this report describing the steps taken to implement the VE pilot, its overall impact on public protection, and presenting its recommendation that the Legislature take the final step in the VE model and effect the transfer of MBC investigators to the Health Quality Enforcement Section of the Department of Justice.

If the Legislature believes the transfer of investigators to DOJ is not warranted at this time, MBC suggests the VE model still would be improved by clarification of the statute, instituting meaningful attempts to co-locate prosecutors and investigators, and immediately creating a new classification for MBC investigators with a pay scale equivalent to DOJ special agents to enable MBC to retain its experienced investigators in which it has invested significant funds, training resources and time.

Introduction

This report addresses the provisions of SB 231 (Figueroa, ch. 674, Statutes of 2005) that require the Medical Board of California (MBC or Board), in consultation with the Departments of Justice, Consumer Affairs, Finance and Personnel Administration, to make recommendations to the Governor and Legislature on the vertical prosecution pilot. (Gov. Code, § 12529.6) This landmark piece of legislation contained a number of legal and practical improvements to the Board's enforcement program, following a two-year study by the MBC's Enforcement Monitor.

Under SB 231, effective January 1, 2006, the MBC and the Health Quality Enforcement Section (HQES) of the Department of Justice (DOJ) were required to implement a vertical prosecution (VP) model to conduct its investigations and prosecutions. Under this legislatively defined VP model, each complaint referred to an MBC district office for investigation is simultaneously and jointly assigned to an MBC investigator ***and*** an HQES deputy. The goal of this model is to increase public protection by improving the quality of investigations, increasing teamwork and efficiency, and shortening the time to resolve assigned cases. Additionally, the Board hoped this new relationship between MBC and DOJ would enhance the Board's ability to recruit and retain experienced investigators.

Throughout much of the legislative process, SB 231 contained a provision which specified that MBC investigators would be transferred to the DOJ, thus creating a more streamlined and centralized enforcement system to achieve the public protection goal. However, shortly before it was enacted, SB 231 was amended and this proposed transfer of investigators was deleted. Instead, as amended, SB 231 created a VP pilot under which investigators continued to be employed and supervised by the MBC while, at the same time, they are responsible for conducting investigations under the direction of HQES deputy attorneys general. While implementation of this unanticipated hybrid VP pilot has presented significant challenges to both agencies, based on the statistical data collected over the first 16 months of this pilot, it

appears that the legislative goal of increasing public protection through faster and more efficient case resolutions is being achieved. By law, this VP pilot becomes inoperative on July 1, 2008, and is repealed on January 1, 2009, unless a later enacted statute deletes or extends it.
This report presents:

- the significant steps taken by both MBC and HQES in the implementation of the VP pilot;
- the overall findings and statistical data showing the results of the VP pilot for the period of January 1, 2006 to April 9, 2007;
- recommendations of the MBC regarding the VP pilot;
- and finally, summarizes an historical overview of the MBC enforcement program.

NOTE: The new vertical prosecution model impacts both the ***investigative*** and the ***prosecutorial*** phases of enforcement. Unlike a county district attorney's office, which is solely engaged in criminal prosecution, not all MBC cases lead to prosecution; therefore, vertical prosecution is a misnomer. MBC refers to the new model as a **vertical *enforcement* (VE) model**. Throughout this report, the vertical prosecution model will be referred to as the vertical enforcement (VE) model.

Implementation

On January 1, 2006, the Medical Board of California (MBC) and Health Quality Enforcement Section (HQES) of the Department of Justice (DOJ) implemented the vertical prosecution model, as mandated by section 12529.6 of the Government Code ***(Refer to Appendix B)***. This model, a two-year pilot program, is a new concept never before implemented by another state agency. Implementation of this unique model, where members of the team are from two different governmental agencies with separate hiring authorities, communications systems, and chains-of-command, has presented significant challenges. To meet those challenges, MBC and HQES have taken significant steps, both individually and jointly, to successfully implement the program.

Vertical Enforcement as Defined in SB 231

Throughout much of the 2005 legislative process, SB 231 contained provisions which specified that MBC investigators would be transferred to the DOJ, thus creating a more streamlined and centralized enforcement system. Since HQES is already statutorily responsible for prosecuting MBC cases, having the investigators under its jurisdiction seemed a logical choice. However, shortly before it was enacted, SB 231 was amended and this proposed transfer of MBC investigators was deleted. Instead, as amended, SB 231 created a pilot under which investigators continue to be employed and supervised by MBC while, at the same time, they are responsible for conducting investigations under the direction of HQES deputy attorneys general. While the MBC investigative process is essentially unchanged under the VE model, the changes within HQES, both structurally and procedurally, have been more dramatic. For example, under the new VE model, HQES has been required to:

- Develop a database for all cases referred for investigation, not just those that are prosecuted

- Develop familiarity with all MBC policies pertaining to investigations

- Become responsible for all elements of the investigative process on cases resulting in closure or prosecution

- Provide case direction from the investigative stage through the prosecutorial stage

- Prioritize a new workload, which included investigative and prosecutorial tasks

Implementation of this unique VE model mandated by SB 231 has proved challenging, with authority to direct investigators coming under HQES jurisdiction while, at the same time, authority for investigator supervision remaining with MBC. Both the MBC and HQES continue their efforts to meet and overcome these challenges, in a spirit of cooperation, to achieve the legislative goals of SB 231.

HQES and MBC met throughout calendar years 2005 and 2006 to discuss issues, such as: how to handle the large volume of pending pre-VE cases, protocols the agencies would utilize, how communication by the VE teams would be undertaken, and how success of the pilot would be measured. Senior management from both agencies discussed the global issues impacting the pilot, while task forces were established to examine pre-VE policies, create new procedures and select reporting formats.

Both agencies agreed the VE pilot included three basic elements. First, each complaint of alleged misconduct by a physician and surgeon referred to an MBC office for investigation must be simultaneously and jointly assigned to an MBC investigator and HQES deputy attorney general. Second, that joint assignment must exist for the duration of the case. Third, under the direction of a deputy attorney general, the assigned MBC investigator is responsible for obtaining the evidence required to permit the Attorney General to advise the MBC on legal matters such as whether a formal accusation should be filed, dismiss the complaint, or take other appropriate legal action. (Gov. Code, § 12529.6.)

The MBC's Enforcement Operations Manual, a compilation of Enforcement Program policies and procedures, required modifications to comport with SB 231. After the revisions were made, they were carefully reviewed by both the MBC and HQES to ensure consistency and agreement. Because the Enforcement Monitor highlighted MBC's inability to meet the 180-day legislative

goal for non-complex investigations and the one-year goal for complex investigations (Bus. &Prof. Code, § 2319), efforts were undertaken to assess the MBC's policies. Consequently, new policies were developed to address delays encountered when seeking to obtain medical records and conducting physician interviews.

MBC staff also defined the criteria for a "complex" investigation.[1] After applying this criteria to the current caseload, 40% of the caseload met the definition of "complex."

SB 231 stated that investigations were under the "direction" of HQES; however, the statute did not define "direction" or provide guidance on how to implement the VE model. While initially unable to reach agreement on a joint manual, HQES, in January 2006, published its "Vertical Prosecution Manual for Investigations Conducted by Medical Board Investigators (First Edition, January 2006)," and both HQES and MBC published their "Joint HQE/MBC Vertical Prosecution Protocol (First Edition, January 2006)." HQES and MBC renewed their efforts to develop a joint manual and, in November 2006 successfully and jointly published their "Vertical Prosecution Manual (Second Edition, November 2006)." *(Refer to Appendix C.)*

The DOJ has also made significant modification to its ProLaw computer software used to track investigations and prosecutions. In an effort to overcome co-location barriers, HQES also installed upgraded computers in each MBC district office for use by the deputy attorneys general.

A new investigative report format was instituted at the beginning of the VE model to enable investigators to advise DAGs of case progress on an ongoing basis. Minimally, the investigator and the assigned DAG will confer at three stages of an investigation: 1) upon initial case assignment; 2) prior to the interview with the subject physician, and 3) prior to the submission of case documents for an expert review.

Generally, new governmental programs are rarely implemented in a vacuum and the VE model was no exception to this rule. All new complaints received in MBC offices after January 1, 2006 have been investigated under the new VE model. However, as of December 31, 2005, there were

[1] On December 31, 2005, there were 140 allied health investigations in the MBC workload. This is also part of the MBC investigator workload from other DCA licensing boards and committees, in addition to the physician and surgeon cases which were the focus of the VE pilot.

1,014 pending physician and surgeon cases under investigation. Thus, while HQES and MBC were in the process of implementing the VE model, they continued to handle this large volume of cases primarily under the former HQES Deputy-in-District-Office ("DIDO")[2] model, where, upon completion, the investigation was transmitted to HQES for prosecution. At the present time, the majority of these pre-VE cases have been resolved.

[2] Under the former Deputy-in-District-Office ("DIDO") program, which existed prior to the enactment of SB 231, a deputy attorney general was required to "frequently be available on location at each of the working offices at the major investigation centers of the Board, to provide consultation and related services and engage in case review with the Board's investigative, medical advisory, and intake staff." (Former Gov. Code, §12529.5(b))

Findings and Analysis

SB 231 created a vertical enforcement (VE) pilot with investigative and prosecutorial team members in two separate agencies. While considerable progress has been made in developing new policies and procedures, defining participants' roles, and creating a team environment to implement the VE model, the fundamental structural barrier of having investigators employed by one agency, while their workload is being directed by employees of another, still remains. Notwithstanding those challenges, statistical data demonstrate that under the VE pilot, cases that should be closed are more quickly identified and egregious complaints are being handled more expeditiously – both resulting in a greater measure of public protection.

The statistical data collected by the MBC for the first 16 months of the VE pilot, when modified to exclude pending pre-2006 cases, shows an overall decrease of 10 days (from 146 to 136 days) in the average time to complete an investigation. Significantly, this decrease has been accomplished with existing staff, with no augmentation to restore the investigator positions lost during the FY 2002-2003.

The Legislature has established a goal that "...an average of no more than six months will elapse from the receipt of the complaint to the completion of the investigation." (Bus. & Prof. Code, § 2319.) That period is increased to one year for cases involving "...complex medical or fraud issues or complex business or financial arrangements." (*Id.*) In response to the Enforcement Monitor's recommendations to reduce investigative time lines, MBC identified those cases which would fit the definition of "complex" as discussed in the "Implementation" section of this report.

Initial statistical data from the pilot period identify trends which suggest the VE model can more quickly identify cases for closure and certain egregious complaints can be handled more expeditiously. The data also suggested progress in reducing the time frames to complete investigations. However, the pilot time frame was insufficient to address the Enforcement

Monitor's concerns regarding the time to complete prosecutions. Since certain MBC investigations can take one year to conduct, the pilot time frame did not provide adequate time to measure the prosecutorial time line of such cases. It is anticipated that the time frame for the litigation phase will be lessened with the earlier involvement of the deputy attorney general in the case and the continuing availability of the investigator to assist at the hearing.

The MBC's Annual Reports and statistical data reported by the Enforcement Monitor were used to draw comparisons to the data accumulated during the VE pilot (January 1, 2006 through April 9, 2007).

MBC Annual Report Data Re: Time to Complete Investigations

The MBC's computerized data system, Consumer Affairs System (CAS), is used by the Board to gather data for its publications and Annual Report. As reported, the average number of days to complete an investigation was: 208 in FY 2002-03; 220 in FY 2003-04; 259 in FY 2004-05 and 277 in FY 2005-06. While this data shows an increase in the number of days to complete investigations, several significant factors which directly impact these numbers must be considered:

- Vacant and lost investigator positions lead to longer time lines to complete investigations. In FY 2002-03, the Governor's mandated staffing reduction lowered the number of investigators by 19.

- Beginning in FY 2002-03, and continuing to the present, MBC implemented changes pursuant to SB 1950 (Figueroa, ch. 1085, Statutes of 2002) which provided the Board with a new prioritization of complaints and investigations. The Board staff also took steps to reduce the number of cases sent to the district offices for investigation without impacting public safety concerns. Some complaints were resolved in the MBC Central Complaint Unit (CCU) via "cease and desist" letters; some complaints resulted in the issuance of citations; while other complaints e.g., violations involving criminal conviction, were forwarded directly to HQES. Eliminating these simpler investigations from the district office workload has resulted in the field receiving only the more time-intensive and complex cases. Thus, the

apparent increase in length of time necessary to complete investigations appears to be the result, at least in part, the elimination of these less-complex investigations from the statistical data base.

- SB 1950, implemented in FY 2003-04, added section 2220.08 to the Business and Professions Code which requires CCU to have all quality-of-care complaints reviewed by a medical expert who is in the same specialty as the subject physician before these complaints were sent to the MBC district offices for formal investigation. This resulted in fewer cases being sent to the district offices. Some of these cases were marginal and often those cases were completed quickly when sent to the district office. With this procedural change, these cases were closed in CCU and impacted the average time for completion of investigations.

- Beginning in FY 2004-05, MBC instituted another procedural change to the way data was collected and reported. All citations initiated from CCU, including those stemming from a physician's failure to notify MBC of a change of address, were no longer reported as a complaint or an investigation. (They were only reported in the annual statistics as citations issued.) Previously these had been reported as cases opened and closed the same day, and impacted the average time for completed cases.

Monitor's Report: Cycle Time for Completed Investigations

The Enforcement Monitor focused attention on MBC's case cycle time (the time that elapses between receipt of a complaint to completion of the investigation related to that complaint). The Monitor's Initial Report presented time frames for completion of investigations by disposition and day range. Table 1 below indicates that, in FY 2003-04, the average elapsed time from receipt of an investigation to case resolution was 261 days, as reflected in the following chart:

Table 1 FY 2003-2004 Investigative Time Frames by Disposition and Day Range

Day Range	Non-Legal Closure		Referred for Legal Action		Total	
	Number	Percent	Number	Percent	Number	Percent
1 Month or Less	83	7.0	144	23.8	227	12.7
1 to 3 Months	133	11.2	36	6.0	169	9.4
3 to 6 Months	239	20.2	80	13.2	319	17.8
6 to 9 Months	248	20.9	69	11.4	317	17.7
9 to 12 Months	195	16.5	80	13.2	275	15.4
12 to 18 Months	206	17.4	110	18.2	316	17.7
18 to 24 Months	67	5.7	67	11.1	134	7.5
More than 24 Months	14	1.2	19	3.1	33	1.8
Total	1185	100.0	605	100.0	1790	100.0
Average Time frame	256 days		269 days		261 days	

To contrast the Monitor's data, the same criteria was applied to the CAS data, for calendar year 2006 (the VE pilot period). On December 31, 2005, 1,014 physician and surgeon investigations were pending in the MBC district offices. In calendar year 2006, 1,090 physician and surgeon cases were referred to the field. Thus, 2,104 cases were in varying stages of investigation during this pilot period and the average elapsed time from receipt of an investigation to case resolution was 282 days, as reflected in Table 2 below.

Table 2 CY 2006 Investigative Time Frames by Disposition and Day Range

Day Range	Non-Legal Closure		Referred for Legal Action		Total	
	Number	Percent	Number	Percent	Number	Percent
1 Month or Less	25	3.3	107	24.7	132	11.0
1 to 3 Months	61	8.0	19	4.3	80	6.7
3 to 6 Months	128	16.7	68	15.7	196	16.4
6 to 9 Months	142	18.6	65	15.0	207	17.3
9 to 12 Months	164	21.4	44	10.1	208	17.3
12 to 18 Months	181	23.7	82	18.9	263	21.9
18 to 24 Months	52	6.8	36	8.3	88	7.3
More than 24 Months	12	1.5	13	3.0	25	2.1
Total	765	100.0	434	100.0	1199	100.0
Average Time frame	296 days		256 days		282 days	

A comparison of Table 1 to Table 2 appears to reflect an increase in average case investigation time from 261 days (FY 03-04) to 282 days (CY 06). However, data modifications are necessary to both charts because they include a significant number of cases that were in the workload ***prior*** to the start of the time period under analysis. The 2003-04 chart also included workload that is no longer sent to the district offices, due to changes in MBC and CCU policies.

Table 3 below reflects these modifications. For cases that were initiated ***and*** completed during FY 2003-04, the average time to complete investigations was 146 days.

Table 3 **FY 2003-2004 Investigative Time Frames by Disposition and Day Range for Investigations Initiated and Completed in FY 2003-2004 (This excludes out-of-state and headquarters cases.)**

Day Range	Non-Legal Closure		Referred for Legal Action		Total	
	Number	Percent	Number	Percent	Number	Percent
1 Month or Less	24	6.8	29	24.2	53	11.1
1 to 3 Months	76	21.3	17	14.2	93	19.5
3 to 6 Months	128	36.0	30	25.0	158	33.2
6 to 9 Months	99	27.8	31	25.8	130	27.3
9 to 12 Months	29	8.1	13	10.8	42	8.8
12 to 18 Months	0	0	0	0	0	0
18 to 24 Months	0	0	0	0	0	0
More than 24 Months	0	0	0	0	0	0
Total	356	100.0	120	100.0	476	100.0
Average Time Frame	148 days		139 days		146 days	

Table 4 below reflects investigative time frames for cases referred for investigation in 2006. Table 4 reveals that, under the VE model the average time to complete an investigation is 136 days.

Table 4 **CY 2006 Investigative Time Frames by Disposition and Day Range for Investigations Initiated and Completed in CY 2006 (This excluded out-of-state and headquarters cases.)**

Day Range	Non-Legal Closure		Referred for Legal Action		Total	
	Number	Percent	Number	Percent	Number	Percent
1 Month or Less	22	11.0	19	24.0	41	14.7
1 to 3 Months	47	23.5	13	26.5	60	21.5
3 to 6 Months	73	36.5	19	24.1	92	33.0
6 to 9 Months	38	19.0	22	27.8	60	21.5
9 to 12 Months	20	10.0	6	7.6	26	9.3
12 to 18 Months	0	0	0	0	0	0
18 to 24 Months	0	0	0	0	0	0
More than 24 Months	0	0	0	0	0	0
Total	200	100.0	79	100.0	279	100.0
Average Time frame	136 days		133 days		136 days	

Table 4 data clearly indicates a reduced time for the disposition of all cases under the jurisdiction of the district offices.

Overview of Investigative Workload During the VE Pilot

The CAS data can be viewed in a different format to assess how investigations progressed during the VE pilot. Table 5 chart represents investigations that were in the system on January 1, 2006, as well as investigations which were added through December 31, 2006. The chart reflects the disposition of these investigations between January 1, 2006 and April 9, 2007:

Table 5 Investigation Dispositions CY 2006

Physician & Surgeon Investigations	Cases Closed with No Action			Citations Issued			Referred for Criminal Action			Referred for Prosecution				Investigations Pending	
	#	%	Avg days	#	%	Avg days	#	%	Avg days	#		%	Avg days	#	%
										Primary Referral	Consolidated Referrals				
1014 pending on 1-1-06	569	56%	378	37	4%	380	17	2%	461	191	51	24%	447	149	14%
1090 opened between 1-1-06 & 12-31-06	305	28%	169	11	1%	198	9	1%	218	80	42	11%	186	643	59%

Investigations Pending on December 31, 2005

1,014 investigations were in the investigators' workload at the inception of the pilot. These investigations were in varying stages of development and may have had significant legal involvement under the former HQES DIDO program. While VE was being piloted, these cases also required attention from the newly formed VE teams. Table 5 above reveals that, of the 1,014 investigations, 569 or 56% of these investigations were closed, with an average completion time of 378 days. Of the remaining 445 investigations, action was taken as follows. 37 citations (4%) were issued; 17 investigations (2%) were referred for criminal action; and 242 investigations (51%) were identified for potential administrative action. Effective April 9, 2007, there were 149 pre-2006 investigations pending.

Investigations Opened After January 1, 2006

Table 5 above reveals that 1,090 investigations were opened and assigned to the VP teams during 2006 calendar year. The VE protocols were utilized in processing these investigations. Of the 1,090 investigations, 305 investigations (28%) were closed, with an average completion time of 169 days. Of the remaining 785 investigations, 13% resulted in the following actions: 11 citations (1%) were issued; nine investigations (1%) were referred for criminal action; and 122 investigations (11%) were accepted for administrative action. The data reveals that the average number of days from receipt of the investigation to the investigation completion and acceptance for administrative action averaged 186 days. Effective April 9, 2007, there were 643 investigations (59%) pending.

The data in Table 5 suggests that a large body of work was processed by the team members during this period of time. Of the 2,104 investigations, 874 investigations were closed, 48 citations were issued, 26 investigations were referred for criminal action, and 364 investigations were referred for administrative action. The VE teams worked on the older investigations in the system, as well as focused attention on the newer investigations.

In addition to decreased investigation completion and accusation filing times, the VE model has led to significant improvements in other areas that were the subject of concern by the Enforcement Monitor.

Comparison of Case Closure Data

Within the 2006 calendar year, it took an average of 135 days to close an investigation, which was determined to have "no violation," for those investigations opened during this same year. In FY 2003-04, it took 154 days. This data suggests the VE team is able to identify those investigations which should be removed from the investigative workload earlier in the time line.

During the VE pilot period, it took 139 days to close an investigation that had insufficient evidence to result in a prosecution, whereas in FY 2003-04 it took 145 days. This also suggests these types of investigations are being pulled out of the workload more quickly.

Delays in Obtaining Medical Records

The Enforcement Monitor reported there were significant delays in the time it took for MBC to obtain medical records. In FY 2003-04, the average time from a request for records by MBC to the receipt of all records was 74 days. Subsequently, the Enforcement Program instituted a zero-tolerance policy change for failure to provide medical records in a timely manner pursuant to Bus. & Prof. Code, § 2225 and § 2225.5. The policy was vetted through MBC and HQES, revised in the MBC Enforcement Operations Manual, and distributed to all investigative staff. For cases in the VE pilot assigned in calendar year 2006, the average time to retrieve records was 36 days.

MBC and HQES staff have been diligent to ensure the zero-tolerance policy is enforced and citations have been issued for failure to provide records in a timely manner. The VE pilot has enabled increased participation by DAGs in record acquisition. It appears the involvement of the Department of Justice also has been instrumental in garnering cooperation from law offices, hospitals, physician offices and governmental entities in providing medical records expeditiously.

Delays in Physician Interviews

The Enforcement Monitor reported there were inconsistent MBC policies and, therefore, delays in conducting interviews with subject physicians. The average time between the initial request for an interview and the actual subject interview was 60 days.

For investigations in the VE pilot assigned in calendar year 2006, the average time to request an interview with a physician to the completion of the physician interview was 40 days.

The MBC and HQES staff have used their subpoena authority to compel a physician to appear for an interview when there have been delays in appearances.

Delays in Obtaining Medical Expert Opinions

The Enforcement Monitor reported MBC had a policy and a goal of obtaining the expert opinion in 30 days. In FY 03-04, the number of days between the time a completed investigation was sent to an expert reviewer and the time the expert opinion was returned to the investigator was 69 days.

MBC data for the request and receipt of an expert opinion in the VE pilot is 36 days.

As part of the VE pilot, HQES DAGs were encouraged to interact with the medical consultants to ensure the appropriate medical expert was selected. This has reduced the number of times a subsequent expert opinion was necessary. The involvement of DAGs earlier in the investigation has served to identify the materials essential for the expert's review, thus eliminating the need for the expert's review of unnecessary documents. When the expert opinion is returned, the DAG can quickly assess the opinion to determine if the expert has followed the guidelines and if the opinion has addressed all the substantive issues referenced in the complaint. If the expert opinion requires clarification, the DAG can readily request clarifying information, rather than waiting for the issue to be resolved at the time of trial. This also can eliminate the unnecessary filing of administrative charges.

Number of Accusations and Elapsed Time for HQES Filing

The Enforcement Monitor had concerns about the delays in filing accusations from the date HQES received the investigation. Table 6 below compares cases investigated from calendar year 2006 and accepted by HQES for administrative action between January 1, 2006 through April 9, 2007.

Table 6 Average days to file Accusation

	Accusations Filed				Number of accusations filed where the info from consolidated case is in Accusation (incl in Accusations filed also)	Amended Accusation filed based upon consolidated case information	Disciplinary Actions Taken	
	#	% of referred	Average days from investigation assigned to filing	Average days from completion of investigation to filing			#	Average days from completion of investigation to outcome
1014 investigations pending as of 1-1- 06	102	53	569	110	23	9	36	217
1090 investigations were opened between 1-1-06 and 12-31-06	36	45	212	80	14	8	8	130

Investigations Pending on December 31, 2005[3]

Of the 1,014 (pre-VE) investigations pending in the MBC investigator workload, 242 investigations were accepted by HQE with an average of 447 days from the start of the investigation to the acceptance of the case. (Note: These include 191 primary referrals and 51 consolidated case referrals, which are subsequent cases on the same physician.) Table 6 above indicates that of the 242 investigations, 102 investigations (53% of the 191 primary referrals) resulted in the filing of an accusation by the end of CY 2006. The average number of days from

[3] On December 31, 2005, there were 140 allied health investigations in the MBC workload. This is also part of the MBC investigator workload from other DCA licensing boards and committees, in addition to the physician and surgeon cases which were the focus of the VE pilot.

the start of the investigation to this filing date was 569 days. The average time from investigation completion to the filing of administrative charges was 110 days. Final outcome was achieved for 36 investigations in an average of 217 days from the completion of the investigation to the final outcome.

Investigations Opened After January 1, 2006 [4]

Of the 1,090 investigations opened after January 1, 2006, 122 VE investigations were accepted by HQES for administrative action (80 primary referrals and 42 consolidated case referrals),with an average of 186 days from the start of the investigation to the acceptance of the case. Table 6 above indicates that of the 122 investigations, 36 investigations (45% of 80 primary referrals) resulted in the filing of an accusation by the end of CY 2006. The average time from the start of the investigation to this filing date was 212 days. (Note: As a comparison, for investigations opened in FY 2003-04 with filings within 15 months, it took an average of 241 days.) During the VE pilot, the average time from investigation completion to the filing of administrative charges was 80 days. (Note: In contrast, the FY 2003-04 Annual Report reflected 107 days for an investigation to progress to this point.) In the VE pilot, final outcome was achieved for eight investigations, in an average of 130 days from the completion of the investigation to the final outcome. (Note: As a comparison, for investigations opened and resolved in calendar year 2004, with outcomes within 15 months, 161 was the average number of days.)

During the pilot, all prosecutorial time frames have decreased. It is significant to note that of the investigations initiated during calendar year 2006 which were accepted by HQES for the filing of an accusation, 45% already have an accusation filed. This suggests that having the legal review earlier in the investigation has led to quicker action on those cases that are filed.

[4] During calendar year 2006, 183 new allied health investigations were opened. This is also part of the MBC investigative workload from other DCA licensing boards and committees, in addition to the physician and surgeon cases which were the focus of the VE pilot.

ISO/TRO filings and Elapsed time for filing

The Enforcement Monitor was critical that MBC appeared to have underutilized the Interim Suspension Order (ISO) and Temporary Restraining Order, (TRO) tools that provide extraordinary relief from those physicians who may pose an imminent threat to public safety.

Although the monitor did not measure elapsed time to obtain these orders, the time frame in FY 2003-04 from the receipt of the investigation to the granting of the orders was 283 days. In calendar year 2006, the elapsed time from the receipt of the investigation to the granting of these orders was 274 days.

In FY 2003-04, the monitor noted 22 ISOs/TROs were granted, regardless of the date of when the investigation was initiated. From January 1, 2006 through December 31, 2006, 23 ISOs/TROs were obtained regardless of when the investigation was initiated.

These numbers alone do not represent a significant increase. Upon further examination of the underlying case data, it was determined that six ISOs/TROs were granted in FY 2003-04 based upon investigations initiated during that same time frame and these took an average of 91 days. In contrast, in calendar year 2006, eight ISOs/TROs were granted based upon investigations initiated during this period, which took an average of 30 days. This data reflects a 67% reduction in the amount of time to obtain an ISO/TRO, thereby demonstrating enhanced public protection.

Successes, Challenges and Recommendations

Over the years, the Legislature has periodically reviewed the MBC's performance and taken important steps to refine its operations to further improve public protection. The implementation of the VE model mandated by SB 231 was another important step in that effort. The preliminary data suggests there have been decreases in all time frames relating to the investigation and prosecution of VE cases. This improvement has occurred even though the MBC has experienced investigator retention and recruitment issues associated with the uncertainty of this pilot. HQES also had to fill nine vacancies and there is a learning curve associated with new employees. This

suggests that in the future a full complement of experienced team members may lead to further decreases in the time frames of enforcement activities. There are positive and negative factors which impact the success of the current pilot, as detailed in the following pages:

Successes:

- 2,104 pending investigations were in process during the VE pilot period. 1,014 cases were pending prior to the VE pilot and 1,090 investigations were assigned during calendar year 2006. Of those, 1,312 reached disposition (865 pre-VE and 447 post-VE): 874 investigations were closed (569 pre-VE and 305 post-VE); 48 citations were issued (37 pre-VE and 11 post-VE); 26 investigations were referred for criminal action (17 pre-VE and nine post-VE); and 364 investigations were referred for disciplinary action (242 pre-VE and 122 post-VE).

- Investigations that result in a finding of no violation or insufficient evidence are being closed more quickly. In FY 03-04, it took 154 days to close "no violation" cases, while in calendar year 2006, it took 135 days. In FY 03-04, it took 145 days to close "insufficient evidence" cases, while in calendar year 2006, it took 139 days. Both consumers and physicians directly benefit when such investigations are quickly resolved.

- Medical records are being obtained more quickly. In FY 03-04, it took an average of 74 days to obtain medical records. In calendar year 2006, it took an average of 36 days. Some of this reduction in time may be the result of law passed in 2005 giving MBC citation and fine authority for failure to provide records in 15 days. (Bus. & Prof. Code, § 2225 (d)).

- Physician interviews are occurring in a more timely manner. In FY 03-04, it took an average of 60 days to conduct interviews with subject physicians. In calendar year 2006, it took 40 days.

- The average time for receipt of a medical expert opinion has been reduced by 40%. In FY 03-04, it took an average of 69 days to obtain the medical expert opinion. In calendar year 2006, it took 36 days. Implementation of a new policy compelling physicians to appear

through use of subpoena power may have contributed to this time savings along with the attorney participation in the VE pilot.

- Accusations are being filed faster. In FY 03-04 it took an average of 241 days from the date the case was initiated to the date an accusation was filed. In 45% of the investigations initiated during calendar year 2006 through April 9, 2007 and approved for filing by HQES, accusations were filed within an average time of 212 days.

- Petitions for Interim Suspension Orders (ISOs) and Temporary Restraining Orders (TROs) in emergency cases are being filed faster. ISOs/TROs initiated in FY 03-04 took an average of 91 days. In calendar year 2006, they took an average of 30 days. Clearly, the assumption is that early involvement of a DAG reduces the time to initiate these actions.

While the VE pilot has plainly demonstrated substantial public protection benefits, it is unclear whether further significant improvements can be obtained under the present model. The loss of experienced MBC investigators as a result of continuing the pilot in its present state may ultimately undermine the very public protection goals it was originally enacted to achieve. In this regard, the MBC presents the following.

Challenges:

- There are significant retention problems with MBC investigative staff which have existed for many years due to factors common in many law enforcement agencies. Recruitment of entry level personnel followed by a number of years of training and experience creates a work force eligible for and interested in jobs found elsewhere outside of the MBC that, for a variety of reasons, including higher pay, may be more attractive. This problem may have been exacerbated recently with MBC investigators who were led to believe they might soon be transferred to DOJ (and receive a higher salary) and instead were engaged in a "pilot" study.

(Note: On January 1, 2006, MBC had 92 sworn staff positions comprised of 71 investigators and 21 supervisors. On July 1, 2006, SB 231 augmented staff by four investigator positions, bringing the total to 96. Of the 96 authorized positions, there was an average statewide vacancy rate of

12.3% during calendar year 2006, which equates to 11.6 positions being vacant thereby resulting in an increased workload for the remaining investigators. From January 2006 to present, there were 19 investigator separations [six retired, two resigned, and 11 transferred]. Of the 11 transfers, two went to DOJ; two went to Corrections; five went to D of I; one went to Lottery; and one went to DHS. Although this vacancy rate may be consistent with other state agencies, when it is coupled with the time required for backgrounds and training, the impact is magnified.)

- In conducting exit interviews, many investigators have cited the major reason for such a high rate of exodus as due to MBC's lower salaries and more complex workload than other agencies. In addition, many retired investigators indicated that they may have chosen to work for more years if the workload were reduced and the pay increased.

- Vacancies have occurred when investigators have transferred out of the MBC due to the uncertainty associated with the pilot. Simply put, the temporary nature of a pilot does not allow for long-term planning for investigators' careers. MBC anticipates that the continuation of the pilot in its current state will result in further loss of experienced MBC investigators.

- Some experienced MBC investigators also have been attracted to the DOJ special agent classification due to the prestige and enhanced benefits associated with that classification.

- There is reason to believe the VE pilot may have hindered the recruitment efforts of MBC investigators. New applicants have questioned the future of the MBC investigator position and have been reluctant to join an investigative agency with such an uncertain future.

- Supervisory investigator positions have remained vacant for longer periods of time. Two supervisors chose to voluntarily demote and some investigators were reluctant to promote due to the changing environment and greater demands of VE.

- The VE pilot has led to some role confusion by deputy attorneys general and investigators as the terms "direction" and "supervision," as used in the statute, were not clearly defined and are subject to interpretation.

Recommendations:

The statistical data collected by the MBC, while limited, has shown a decrease in all of the time periods related to the investigation and prosecution of cases under the VE model. MBC concludes that significant benefits to both consumers and licensees are achieved under a VE model. At the same time, it is unclear whether any further improvements are possible under the existing VE pilot structure. Therefore, MBC recommends the following options:

1. **Transfer the MBC investigators to the DOJ HQES.**
   This option would allow co-location of deputy attorneys general and investigators which would lead to identified teams working together in a more cohesive fashion, help reduce travel times, build stronger working relationships, and allow for the use of a single computer data base which would track both investigative and prosecutorial functions. This may also lead to more rapid resolution of investigations that do not warrant disciplinary action, thereby allowing more time to be spent on complex cases.

2. **Continue the pilot for another two years to obtain more data.**
   If the Legislature and the Administration believe that the limited time frame of this pilot does not provide sufficient data to measure improvement and justify the transfer of MBC investigators to HQES, an alternative is to continue the pilot for another two years to obtain additional data. If this option is chosen the pilot should be strengthened with the following:
   A. The statutes enabling the pilot should be amended to eliminate some of the confusion caused by the current statute as it relates to the ability of the deputy attorneys general to "direct" the investigator.
   B. The statute should be amended to allow MBC to utilize the Special Agent classification, used by the Department of Justice, to employ investigators to conduct complex and varied disciplinary investigations.

3. **Continue the pilot for another two years.**
   If the Legislature and the Administration believe that the limited time frame of this pilot does not provide sufficient data to measure improvement and justify the transfer of MBC investigators to HQES, an alternative is to continue the pilot for

another two years to obtain additional data. If this option is chosen the pilot should be strengthened with the following:

A. The statutes enabling the pilot should be amended to eliminate some of the confusion caused by the current statute as it relates to the ability of the deputy attorneys general to "direct" the investigator.

B. The statute should be amended to allow MBC to establish an MBC investigator series to include pay commensurate with the DOJ Special Agent classification.

4. **Continue the pilot for another two years plus give MBC the statutory authority to contract with DOJ for a percentage of investigative services.**
The ability to contract with the DOJ for a percentage of investigative services while continuing the pilot would allow a side-by-side comparison system, i.e., investigators and deputy attorneys general working in teams in the same department versus the current pilot.

5. **Establish a pilot providing MBC with the statutory authority to create a legal unit within MBC that can hire attorneys to prosecute MBC cases.**

The MBC also recommends the term "vertical prosecution" as referenced in SB 231 be changed to "vertical enforcement" in future legislation to more accurately describe the process.

APPENDIX A

History

Vertical Enforcement Defined

The term "vertical prosecution" (VP), as defined in the Enforcement Monitor's Initial Report,[5] refers to the continuous involvement of attorney and investigator team members as a case works its way through the investigative and prosecutorial process. Investigators and prosecutors work together in teams from the date a case is assigned for investigation. The purpose of this combined effort is to prepare complex investigations for trial or some other legal disposition. It is often visualized as a vertical chain of events beginning with investigation and proceeding to pleadings, preliminary examinations, pre-trial motions, trials and appeals. While these terms are common to criminal proceedings where VP is used, the majority of MBC cases will result in a disposition other than prosecution. The term "vertical enforcement" (VE) more accurately describes the process of investigating MBC cases and includes those cases that will be closed without formal action.

In the VE model, the investigation benefits from having legal guidance and assistance from the HQES deputy attorney general at the initial assignment of the case. Under this model, the trial attorney and the investigator are assigned as a team to handle a complex case as soon as it is opened as a formal investigation. The team approach refers to the team assembled for a particular case, allowing for experts or certain specialists to be added to the case, as may be required. In some agencies, different teams are formed for different types of cases, thus maximizing training and the development of different working relationships.

[5] Enforcement Monitor *Initial Report,* November 2004, page 134 (including footnote #172)

While the prosecutor and the investigator work together during the investigative phase to develop the investigative plan and ensure the gathering of necessary evidence to prove the elements of the offense, they have very different roles. The prosecutor brings the expertise to anticipate legal defenses; provide legal analysis of the incoming evidence to help shape the direction of the case; assist with uncooperative subjects or third-party witnesses; deal directly with defense attorneys when issues arise; and address settlement or plea matters. In turn, the investigator contributes a peace officer's experience and insight into the investigative plan and case strategy; performs the field investigative tasks, including identification and location of witnesses and subjects; interviews witnesses and subjects; obtains and participates in the review of documentary and technical evidence; assesses criminal histories and other databases; identifies and assists with experts; plans and executes undercover operations; prepares affidavits and specifications for search warrants; serves warrants; makes arrests; assists with witnesses and evidence during the trial phase; prepares investigative reports; and conducts other tasks usually associated with the work of trained peace officers and professional investigators.

Enforcement Monitor's Recommendation

SB 1950 (Figueroa, ch. 1085, Statutes of 2002) appointed an Enforcement Monitor to study the Medical Board of California's Enforcement Program. The study began in November 2003 and occurred over two years. During the first year, the study was devoted to 10 areas including: mission; resources; management structure; complaint, investigation and disciplinary processes; and, the use of medical consultants and medical experts.

During the second year, emphasis was placed on measuring any changes implemented by the MBC during year one, analyzing the last year's fiscal year data and assistance with the drafting and advocacy of legislation introduced as a result of the Enforcement Monitor's recommendations. The Enforcement Monitor's Initial Report, released November 1, 2004, included 55 recommendations relevant to the Board's enforcement program.
(Refer to http://www.mbc.ca.gov/Pubs_Enforcementrept.htm for the full Initial Report.)

The Enforcement Monitor's report concluded that the board's enforcement program was impeded by: time delays in the investigative process; inadequate coordination and teamwork between MBC investigators and HQES prosecutors; delays in procurement of medical records; ineffective policies relating to physician interviews; inadequate medical consultant availability and utilization; weaknesses in the medical expert program; need for ongoing training for MBC investigative staff; need for improved coordination with state and local prosecutors; ongoing problems with recruitment and retention of MBC investigators; need to update existing MBC training manuals; and, MBC investigators could benefit from improved access to various databases. While some of these issues were addressed immediately as the MBC implemented new policies and procedures, others could not be addressed without legislation.

The Enforcement Monitor recognized how MBC cases might benefit from the VE model. The Enforcement Monitor envisioned early and continuing attorney/investigator teamwork that is typically utilized by many other prosecutorial offices when handling complicated cases. Certain complex and difficult law enforcement investigations naturally lend themselves to this model and many MBC cases involve highly technical medical issues, complicated facts, and multiple victims and witnesses.

The monitor envisioned elements of the vertical enforcement model to include:

- Early coordination of the efforts of attorneys, investigators, and other staff;
- Continuity of teamwork throughout the case;
- Mutual respect for the importance of the professional contributions of both attorneys and investigators and the value of having both available in all stages of the case; and,
- Early designation of trial counsel, recognizing that the prosecutor who ultimately puts on the case must be assigned from the case's inception to help shape and guide it because any investigation may have a trial as its ultimate outcome.

The Enforcement Monitor described concerns affecting the existing inadequate attorney-investigator coordination and teamwork. "The performance of the MBC's investigative staff and HQES prosecutors, and the nature of the working relationship between the HQES and MBC, have been studied closely in this project. MBC investigators and HQES prosecutors are hard-working and skilled professionals, and much good disciplinary work is done every day by these dedicated public servants. All parties acknowledge good faith and good efforts on all sides. However, there is clearly room for improvement in the cost, speed, and effectiveness of the administrative enforcement system as presently constituted, as indicated by the lengthy case cycle times and comparatively modest case outputs noted by the state Legislature and other critiques."[6]

Historical Review: MBC Investigations and Prosecutions

The Medical Board of California is a semi-autonomous occupational licensing agency located within the state Department of Consumer Affairs (DCA). It has been in existence since 1876 when the Legislature first passed the Medical Practice Act. From its inception, there existed a need for the MBC to protect healthcare consumers through the vigorous, objective enforcement of the Medical Practice Act. This remains the MBC's mission today. The MBC has two fundamental responsibilities: licensing applicants under the Division of Licensing (DOL) and the investigation of complaints against its licensees, under the Division of Medical Quality (DMQ). The Enforcement Program, housed under DMQ, has made many improvements over the years to maximize efficiency. This historical review will highlight major events which led to the current structure of the MBC's Enforcement Program with an emphasis on the evolving relationship between the MBC investigative staff and the HQES prosecutors.

MBC Investigations During the Early Years

From 1876 to 1913, the Board of Medical Examiners (later renamed MBC) spent most of its energies trying to establish itself as a legal entity with jurisdiction over the medical profession. Little was done to discipline the physician community during this time. The MBC's Enforcement Program was not created until 1913 and initially consisted of one chief counsel and two special agents.

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[6]Enforcement Monitor's *Initial Report*, page 129

In the decades of the 1920s and 1930s many MBC investigations focused on fraudulent diploma "mills" which issued medical credentials, diplomas and licenses for a price. The Enforcement Program staff of four grew to a force of 10 individuals during this period. The state was divided in half with a Northern and a Southern Department. Little change occurred during the next two decades.

In the 1960s, the MBC Enforcement Program was responsible for investigating physician licensees as well as certain allied health licensees, as there was a similarity in the types of violations that were investigated. Common offenses involved improper use of prescription drugs, intemperance, illegal abortions and practicing medicine without a license.

Under Governor Ronald Reagan, a proposal was made and approved to centralize the investigative staff from all the licensing boards into one pool of investigators who were assigned to the newly created Division of Investigation under the renamed Department of Consumer Affairs (DCA). This included all the MBC investigators. The restructuring would allow better organization and training of investigators, and the number of field offices could be expanded to certain geographic parts of the state which were under-served. With this reorganization, the Governor appointed a new chief over the Division of Investigation.

During this time, investigator caseloads often ranged from 75 to 100 cases, with a mix of violations. Cases involving physician misconduct could be discussed with the one medical consultant, who was available to the investigators periodically. In addition there was difficulty in monitoring the progress of investigations. By 1975, the number of DCA licensees had exceeded one million and the number of investigators had increased to more than 100. MBC complaints became backlogged over time and the Board was concerned about inadequate public protection.

MICRA and AB 1xx - 1975

In 1975, AB 1xx (Keene, 2nd Ex Sess., ch.1, Statutes of 1975), known as the Medical Injury Compensation Reform Act of 1975 (MICRA), was created to provide relief from high

malpractice insurance premiums and also included provisions for a massive reorganization of MBC. The Board's name was changed from the Board of Medical Examiners to the Board of Medical Quality Assurance. The new name was intended to better reflect the goal of assuring quality medicine to the citizens of California. Most important, it bolstered the Enforcement Program by increasing its staff by 54 additional technical, consultant, investigative and support positions.

In 1975, biennial physician licensing fees were increased to $175. MBC had sufficient funds to hire investigators who would again specialize in medical investigations. By 1976, approximately half of the investigators from the Division of Investigation were transferred, with their existing caseloads, to MBC, thus forming a new investigative unit.

In 1977, the Chief of Enforcement position was created. Under the direction of a supervising investigator, investigators worked with medical consultants who were now staffed in all field offices. If the evidence revealed a violation of law, the completed investigation was then transmitted, or "handed off," to a deputy attorney general (DAG) in the Department of Justice's Licensing Section. These deputies were located in four major metropolitan areas within the state. The DAGs were not specialized and received assignments involving all licensees under the DCA. MBC cases were commingled with the cases from the Division of Investigation and MBC investigations often received the same priority as cases involving licensed hairdressers, tax preparers and security guards.

The assigned DAGs reviewed the case file to determine if the evidence supported the filing of administrative action against a physician's license. Typically, the investigator and the prosecutor performed their roles separately. The workload volume was high, discussion of case evidence on individual cases was often limited and, in some cases, only occurred if the case went forward to hearing.

Reduced Board Investigator Staffing and Increased Workload

In July 1988, MBC had 700 complaints awaiting investigation. The Chief of Enforcement reported that since the creation of the Enforcement Program in 1977, all efforts to increase the

staff had been denied by the Department of Finance, with the exception of two new investigator positions assigned to the probation surveillance program in 1979. He reminded the Board that three program audits, conducted by the Little Hoover Commission, the Department of Finance and Arthur Young International, had all recommended increasing the staffing of the enforcement program. Because the number of MBC investigators was not increased, annual complaints climbed from 4,265 in 1977 to 6,293 in 1988. In 1977, 2,539 investigations were opened and 2,089 were closed, while in 1988, 2,658 cases were opened with 2,561 closed.

The investigator staffing situation was further complicated in 1988, when the Governor authorized a "golden handshake" retirement option. A significant number of tenured investigators exercised this option to retire early with enhanced benefits and reduced the number of MBC investigators to 40. Faced with a significant number of vacant investigator positions, MBC made a focused effort to recruit, hire and train investigator replacements. The timing of this effort, however, was difficult, as all other state investigative agencies were also faced with vacant positions. Enforcement Program managers also recognized that some state agencies offered investigators caseloads of fewer than 10 cases while MBC investigators averaged 30 cases. Other state agencies were able to offer investigators significantly higher pay and some Board investigators took these offers of employment. Recruitment efforts, coupled with background investigations, also impacted the time span when a selected applicant could begin employment. It was generally recognized that basic training for a new MBC investigator required close supervision for a minimum of one year before the new employee could undertake independent work. The combination of these factors led MBC to take a different approach to address the staffing problem.

In April 1989, when responding to the Legislature on the issue of creating a toll-free number for consumers, the Board took the opportunity to inform the Legislature of its staffing needs to safely protect the public. The Board submitted a report to the Joint Legislative Budget Committee entitled, "*Special Budget Report: Curing the Backlog.*" The report detailed complaint increases over a five-year period and noted that during this same period, MBC had submitted budget requests for 30 additional positions to handle the case growth and resulting backlog. The report recommended 18 permanent new investigator and support staff positions to accommodate case growth, eight limited-term investigator positions, and two limited-term Complaint Analyst positions to eliminate the backlog.

At this same time, the Center for Public Interest Law (CPIL) released its report, *Physician Discipline in California: A Code Blue Emergency*. The report reviewed the MBC Enforcement Program and observed that while more complaints were received, fewer actions were filed and fewer physicians had been disciplined.

The CPIL report was critical of the existing structure whereby MBC had no control over the Licensing Section or the Office of Administrative Hearings, and expressed concern about the time necessary to complete some disciplinary actions. The report offered suggestions for change, including the creation of a unit of prosecutors within the Office of the Attorney General to specialize in medical disciplinary cases. All of these suggestions required legislation.

In May 1989, the Chief of Enforcement advised the Board of the need for additional investigators and detailed efforts by the Enforcement Program to increase MBC investigator's salaries, to be in parity with other comparable state investigative agencies. Based on this discussion, MBC agreed to increase its licensing renewal fees from $175 (1976) to $360 biennially. Later in the year, 18 permanent positions and 10 limited-term positions were added to the enforcement program and two new district offices were created in areas where most of the backlogged cases existed.

AB 184 (Speier, ch. 886 Statutes of 1989) changed the Board's name to the Medical Board of California, effective January 1, 1990. At this same time, a toll-free phone line was installed to make the Board more accessible to consumers and a Centralized Complaint and Investigation Control Unit (later referred to as CCU) was created for more efficient processing of complaints. This new structure allowed for improved communication with consumers on the status of their complaints and eliminated the backlog of unprocessed complaints. The centralized handling of complaints eventually led to redistribution and even orkload assignments to the various district offices and allowed for consistency in the types of complaints that were formally investigated.

Significance of SB 2375

In 1990, SB 2375 (Presley, ch. 1597, Statutes of 1990), also known as the Medical Judicial Procedure Improvement Act, was passed. This bill changed MBC's disciplinary process. It added Government Code § 12529 *et seq.* creating the Health Quality Enforcement Section

(HQES) within the Department of Justice to specialize in prosecuting physicians and other health care practitioners. HQES was required to be "staffed with a sufficient number of experienced and able employees capable of handling the most complex and varied type of disciplinary actions against the licensees of the division or board." (Bus. & Prof. Code, § 12529) HQES was also required to assign attorneys "to work closely with each major intake and investigatory unit... to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations." (Bus. & Prof. Code §12529.5)

SB 2375 also added Bus. & Prof. Code, § 2319 which required MBC to establish a goal that an average of no more than six months would elapse from receipt of a complaint to the completion of an investigation. Cases involving "complex medical or fraud issues or complex business or financial arrangements" had a goal of not more than one year from receipt to completion. Significantly SB 2375 amended Bus. & Prof. Code, § 2229, thereby redirecting the Board's primary priority from physician rehabilitation to public protection.

Recognizing the staff recruitment and retention difficulties of MBC, SB 2375 contained language stating, "It is also the intent of the Legislature that the pay scales for investigators of the Medical Board of California be equivalent to the pay scales for special investigative agents of the Department of Justice, in order to attract and retain experienced investigators." On April 20, 1990, MBC members voted to support SB 2375 with a specified amendment, which stated in part, "Add statutory provisions to raise Medical Board of California investigator salaries to prevent loss of experienced investigators to higher-paying agencies." The objective of the amendment was to get legislative intent recorded to say that the pay scales of the investigators of the Medical Board of California be increased to within 5% of the pay scales for the special agents of the Department of Justice in order to stem the loss of experienced investigators to higher paying state agencies, and to attract new investigators. This amendment was not adopted, but the intent language stayed in the bill.

Efforts to Increase MBC Investigators' Salaries

Consistent with the intent language, in June 1990, the MBC took more action to increase investigators' salaries and provided detailed documentation to DCA outlining investigator vacancies and transfers. Analysis reflected that the duties and level of responsibility of the DCA Special Investigator series were comparable to the DOJ Attorney General investigator, who conducted Medi-Cal fraud investigations. However, in January 1991, DCA proposed that the salary level for the new DCA investigator classification series be aligned to the Department of Corporations investigator series. Three months later, the State Personnel Board established a new series for Investigator, DCA with a salary consistent with the Department of Corporations Investigator series. This represented a 10% salary increase, although MBC investigator salaries were still not aligned with the DOJ Special Agent series.

Response to SB 2375

In early 1991, all backlogged cases were assigned to MBC investigators. The MBC renewed its efforts to increase investigator staffing and received the support of both the Department of Finance and the State and Consumer Services Agency. Fourteen additional investigator positions and 10 support staff positions were requested. These positions were added to the new district offices and reduced caseloads from the 27-30 level, to the 20-23 level.

During this same year, the Office of the Attorney General implemented the provisions of Government Code §12529 and created the specialized HQES to handle disciplinary actions against physicians. Initially, the 22 deputies assigned to HQES set a goal of filing accusations within 60 days of receipt of a referred case. However, HQES was initially understaffed and cases became backlogged in its office.

In April 1991, an Auditor General report found that the MBC would be unable to complete investigations in a six-month period, noting that an average investigation took 14 months. This was attributed to an unusually high vacancy rate in MBC investigator positions and excessive caseloads. The report also found that HQES was taking approximately six months to file an

accusation in a fully investigated case. In the Fall of 1991, the MBC raised its licensing renewal fees to $400 biennially, and agreed to consider another fee increase to finance additional HQES staff.

In 1992, HQES experienced significant delays in filing accusations (486 days). There appeared to be a miscalculation on the number of hours it would require a DAG to review a case, draft pleadings, litigate and follow up on a case. The discussion resulted in an agreement by MBC to fund 27 additional DAG positions and four paralegal positions. To fund these DAG positions as well as more time for administrative law judges, the Board increased its biennial licensing renewal fee to $500.

SB 916

In 1993, SB 916 (Presley, ch. 1267, Statutes of 1993) was passed and again revised the MBC's Enforcement Program. It included a number of provisions and authorized the MBC to increase its biennial licensing renewal fee from $500 to $600.

Investigator staffing problems were exacerbated in 1994 when DPA established a $200 recruitment and retention pay differential for Los Angeles County for incumbents in the Special Investigator and Senior Special classifications for the Department of Motor Vehicles and Employment Development Department. In 1995, the Department of Health Services was added. This same year, DCA submitted a request to DPA for investigator recruitment and differential pay; however, it was denied in 1996.

In March 1995, the Auditor General report, required by SB 916, noted that HQES deputies were assigned caseloads of 30. A backlog of unfiled cases was growing and HQES had requested funding to hire additional attorneys.

During this time, the MBC's Chief of Enforcement reported a 23% increase in complaint volume the prior two years, with no corresponding increase in staff. Investigator caseloads were growing, and there was a 10% vacancy rate in investigator positions because trained MBC investigators were leaving for other agencies with higher pay and lower workload of lesser

complexity. The Chief of Enforcement urged a fee increase to finance investigator positions and attorney positions, but this was denied. In 1996, when the complaint volume further increased and the time for completed investigations increased, the Board voted to seek legislation to increase the biennial licensing renewal fees. At this time, the Board's new executive director sought other fiscal efficiencies in the program and avoided the need for increased fees.

Creation of the "DIDO" Program

In 1997, the "Deputy In the District Office" or "DIDO" program was implemented. This program required a DAG to work in the MBC Central Complaint Unit and in the 12 offices one or more days a week to provide legal assistance and guidance throughout the "lifetime" of a complaint. Conceptually, the DAG would interact with board investigators, and give legal advice on a variety of matters. In CCU, the part-time DAG was primarily involved in the review of complaints and was asked to provide an opinion if a formal investigation was necessary. In the offices, the DAG assisted with active investigations (e.g., subpoena enforcement to help investigators obtain requested medical records; reviewing medical expert opinions to determine if the medical issues were sufficiently described; and reviewing all active cases before they were formally referred to HQES for prosecution).

HQES accusation filing time dropped from 134 days (in 1996) to 90 days as a result of the earlier involvement by an attorney in the investigative design and in the records procurement process. HQES met its goal of filing accusations in a more timely manner. However, the limited interaction allowed by the DIDO program was not always adequate to facilitate the complexity of the MBC investigations. The DAGs assigned to the DIDO Program also had other duties and responsibilities that sometimes prevented them from dedicating all their time to active MBC investigations. The DAGs were assigned active prosecution caseloads, which required them to review the case evidence, prepare legal correspondence, interact with defense counsel, prepare witnesses for testimony, draft subpoenas, prepare for settlement conferences and litigate cases. They were also required to present all cases through the appeals process before the Board, Superior Courts, Courts of Appeal, and Supreme Court. While balancing their trial calendar, DAGs would also provide legal assistance and guidance to investigators on active cases. (However, when cases were formally transmitted to HQES, a DAG, other than the DIDO was

assigned to the case.) Legal strategies sometimes differed, and investigators were sometimes given new direction on these referred cases. As with any "hand-off" method that involves the transfer of a case from one attorney to another, the DIDO model often resulted in a duplication of efforts and delays.

In the fall of 1997, the MBC underwent "sunset" review by the Joint Legislative Sunset Review Committee. The average investigative time cycle to complete a case was 336 days and HQES averaged 134 days of elapsed time from receipt of a case to the filing of an accusation. The MBC investigator caseloads were still high.

In October 2001, Governor Davis imposed a hiring freeze. Although MBC is a special funded agency where salary savings would not assist the general fund deficit, MBC was required to cease the filling of any position which became vacant including investigator positions. During this year, MBC's Enforcement Program reduced the investigative cycle time to 204 days, and an average of 112 days elapsed between HQES receipt of a case and the filing of an accusation.

In Fall 2002, as a result of the continuing budget freeze and budget control language, MBC lost 15.5 positions, which included eight enforcement positions. The hiring freeze continued through FY 2002-03 and FY 2003-04 and imposed an additional 12% budget reduction in personnel. MBC lost a total of 44.8 positions (29 enforcement positions, which included 19 investigators and supervisors). MBC's investigator positions were reduced from 90 in FY 2000-01 to 71 by June 30, 2004, a 24% loss. Due to these same freezes, HQES lost six prosecutor positions assigned to the Los Angeles area.

Enforcement Monitor

In September 2002, SB 1950 (Figueroa, ch. 1085, Statutes of 2002) was signed and made a number of changes to the MBC Enforcement Program. It created an "Enforcement Monitor," who was to be appointed by the DCA Director for a two-year period to study the effectiveness of the MBC Enforcement Program and extended the existence of the MBC until the monitor's findings and recommendations could be evaluated. SB 1950 authorized the MBC to increase its biennial fees from $600 to $610.

In 2003, several changes were implemented in CCU, utilizing "cease & desist" letters and other mechanisms, which resulted in the field receiving only the more time-intensive and complex investigations.

In August 2003, the Enforcement Monitor was appointed pursuant to SB 1950, and provided two reports to the Legislature. The Monitor's Initial Report, released November 1, 2004, described the existing investigative process and contained 55 recommendations for improvement to the Board's enforcement program. MBC implemented many of these recommendations; however, certain changes could not be made without legislation.

SB 231

SB 231 (Figueroa, ch. 674, Statutes of 2005) signed by the Governor on October 7, 2005, made a number of significant amendments. An important part of this new legislation declared that "the Medical Board of California, by ensuring the quality and safety of medical care, performs one of the most critical functions of state government. Because of the critical importance of the board's public health and safety function, the complexity of cases involving alleged misconduct by physicians and surgeons, and the evidentiary burden in the board's disciplinary cases, the Legislature finds and declares that using a vertical prosecution model for those investigations is in the best interest of the people of California." When the Legislature closely studied this situation, they envisioned a need to improve the communication between the MBC investigators and DAGs with the goal of creating more efficient investigations and quicker case resolution.

Throughout calendar year 2005, MBC and HQES managers discussed options for implementing VE. The initial language in SB 231 contemplated the transfer of MBC investigators to HQES. Consideration was given to whether VE could be piloted in a designated geographic area, however this option posed several obstacles including investigator inequity, i.e., permitting a limited number of investigators to transfer to DOJ as special agents may be perceived as unfair by those investigators not permitted to transfer.

MBC researched what other VE models existed in state service. One of the few agencies utilizing a VE models is the DOJ's, Bureau of Medi-Cal Fraud (BMF). MBC recognized that the MBC structure was compatible with BMF and thus MBC could incorporate the BMF model.

Major similarities exist between the MBC and BMF, as follows:

- BMF employs 106 sworn special agents, 31 deputy attorneys general (DAGs),

- 25 auditors and support staff *(MBC employs approximately 100 sworn investigators, and approximately 16 medical consultant positions. HQES is presently staffed with approximately 53 DAGs.)*

- BMF special agents and auditors are housed in 11 offices; prosecutors are located in four separate offices statewide *(MBC has 11 offices and prosecutors are located in four separate offices statewide).*

- The BMF VE triangle "team" consists of an agent, attorney and auditor and the triangle "spins" to focus attention on the lead person who is most responsible for the case at a given juncture. *(MBC's triangle team could consist of an investigator, attorney and, as necessary, a medical consultant.)*

- BMF cases are assigned to an intake special agent and a DAG via a DOJ software program called ProLaw, where documents, photos, audit reports, etc. can be scanned. *(MBC cases could be assigned via the CAS system which could be adapted to exchange information with ProLaw.)*

- BMF special agents and DAGs use computer docking stations and access ProLaw from various offices. *(MBC could acquire the equipment to implement this system.)*

- BMF case discussions are ongoing among the team members, are usually in person, and often take place where the evidence is located. DOJ supervisors can participate in any of these meetings. As necessary, team members communicate via their cell phone or by ProLaw. *(MBC could adopt this method of operation.)*

- BMF disputes regarding case resolution are resolved at the lowest level; however, the special agents can raise their concerns to the BMF Chief. The DAGs can raise their concerns to the BMF Chief DAG. Final dispute resolution rests with the Medi-Cal Fraud Director. *(MBC could adopt this resolution process.)*

SB 231 did not contemplate how the transfer of MBC sworn staff to DOJ would occur, nor was the discrepancy in classification addressed. MBC's Chief of Enforcement met with DOJ labor-relations personnel and learned that DOJ only has one classification for its sworn staff: Special Agent.

In September 2005, the Board's Executive Director met with the Senior Assistant Attorney General for HQES to consider a design for the VE relationship. They envisioned the replacement of the DIDO program with a team of deputies being assigned to each MBC office. They recognized that a significant number of MBC cases result in closure without disciplinary action, and therefore, vertical enforcement of these cases would not be necessary. The HQES team leader was construed to be an "advice and consultation" deputy, who in conjunction with the supervising investigator, would be responsible for assessing every case for its potential for administrative action. If a case was thought to present potential for prosecution, it would be assigned to a deputy to whom prosecutorial responsibility was attached. The major concern regarding the implementation of this model was the lack of sufficient staffing within the Los Angeles metropolitan area. The Senior Assistant Attorney General for HQES believed this model would be phased into various areas of the state as vacant DAG positions were filled.

On October 7, 2005, SB 231 was signed by the Governor. The final version of the law differed dramatically from what either MBC or HQES had envisioned. Throughout much of the legislative process, SB 231 contained a provision which specified investigators would be transferred to the Department of Justice, thus creating a more streamlined and centralized enforcement system. However, shortly before it was enacted, SB 231 was amended and this proposed transfer of investigators was deleted. Instead, as amended, SB 231 created the VE model under which investigators continue to be employed and supervised by the MBC while, at the same time, are responsible for conducting investigations under the direction of HQES deputy attorneys general. SB 231 created a two-year pilot and required this report on the VE model to be submitted to the Legislature by July 1, 2007.

At the November 4, 2005 DMQ meeting, the Chief of Enforcement reported that SB 231 had been signed and a two-year pilot would begin, effective January 1, 2006. This pilot was viewed as a "first step" in a process which would culminate when the investigators and prosecutors were in the same agency.

HQE created a Lead Prosecutor who would be assigned to each office to review all incoming cases and a Primary Deputy who would be assigned to cases where prosecution would go forward. Flexibility would be necessary when deputies were called into trial and to ensure urgent priorities were expeditiously handled. To ensure all members of the team understood their respective roles in the process, new joint operating protocols would be needed. The protocols would clearly define the roles and responsibility of each member while staying focused on the ultimate goal, which was the timely and efficient completion of investigations and, where violations were uncovered, prosecution of the case.

In December 2005, all HQES deputies and MBC investigators attended joint meetings to discuss the implementation of the pilot. The content of SB 231 was discussed, and all attendees were encouraged to be flexible to adapt to necessary changes as the pilot unfolded. New MBC policies, impacted by this new relationship, and which had been vetted by MBC and HQES, were distributed to all participants. HQES deputies were assigned to specific MBC offices and the new teams were introduced. Questions were raised regarding the handling of the pending caseload, which was created under the former DIDO model. There was general agreement that a phasing-in process would be necessary to resolve these cases.

APPENDIX B

Government Code Section

12529. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to investigate and prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California including all committees under the jurisdiction of the board or a division of the board, including the Board of Podiatric Medicine, and the Board of Psychology. (b) The Attorney General shall appoint a Senior Assistant Attorney General of the Health Quality Enforcement Section. The Senior Assistant Attorney General of the Health Quality Enforcement Section shall be an attorney in good standing licensed to practice in the State of California, experienced in prosecutorial or administrative disciplinary proceedings and competent in the management and supervision of attorneys performing those functions. (c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against the licensees of the division or board. (d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, and the committees under the jurisdiction of the Medical Board of California or a division of the board, and the Board of Psychology, with the intent that the expenses be proportionally shared as to services rendered. (e) This section shall become inoperative on July 1, 2008, and, as of January 1, 2009, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2009, deletes or extends the dates on which it becomes inoperative and is repealed. **12529.** (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California including all committees under the jurisdiction of the board or a division of the board, including the Board of Podiatric Medicine, and the Board of Psychology, and to provide ongoing review of the investigative activities conducted in support of those prosecutions, as provided in subdivision

(b) of Section **12529**.5. (b) The Attorney General shall appoint a Senior Assistant Attorney General of the Health Quality Enforcement Section. The Senior Assistant Attorney General of the Health Quality Enforcement Section shall be an attorney in good standing licensed to practice in the State of California, experienced in prosecutorial or administrative disciplinary proceedings and competent in the management and supervision of attorneys performing those functions. (c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against the licensees of the division or board. (d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, and the committees under the jurisdiction of the Medical Board of California or a division of the board, and the Board of Psychology, with the intent that the expenses be proportionally shared as to services rendered. (e) This section shall become operative July 1, 2008. **12529**.5. (a) All complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of California or the Board of Psychology shall be made available to the Health Quality Enforcement Section. (b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to work on location at the intake unit of the boards described in subdivision (d) of Section **12529** to assist in evaluating and screening complaints and to assist in developing uniform standards and procedures for processing complaints. (c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards, division, or allied health committees, including the Board of Podiatric Medicine, in designing and providing initial and in-service training programs for staff of the division, boards, or allied health committees, including, but not limited to, information collection and investigation. (d) The determination to bring a disciplinary proceeding against a licensee of the division or the boards shall be made by the executive officer of the division, the board, or allied health committee, including the Board of Podiatric Medicine, or the Board of Psychology, as appropriate in consultation with the senior assistant. (e) This section shall become inoperative on July 1, 2008, and, as of January 1, 2009, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2009, deletes or extends the dates on which it becomes inoperative and is repealed. **12529**.5. (a) All complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of California or the Board of Psychology shall be made available to the Health Quality Enforcement

Section. (b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to assist the division and the boards in intake and investigations and to direct discipline-related prosecutions. Attorneys shall be assigned to work closely with each major intake and investigatory unit of the boards, to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations. A deputy attorney general of the Health Quality Enforcement Section shall frequently be available on location at each of the working offices at the major investigation centers of the boards, to provide consultation and related services and engage in case review with the boards' investigative, medical advisory, and intake staff. The Senior Assistant Attorney General and deputy attorneys general working at his or her direction shall consult as appropriate with the investigators of the boards, medical advisors, and executive staff in the investigation and prosecution of disciplinary cases. (c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards, division, or allied health committees, including the Board of Podiatric Medicine, in designing and providing initial and in-service training programs for staff of the division, boards, or allied health committees, including, but not limited to, information collection and investigation. (d) The determination to bring a disciplinary proceeding against a licensee of the division or the boards shall be made by the executive officer of the division, the board, or allied health committee, including the Board of Podiatric Medicine, or the Board of Psychology, as appropriate in consultation with the senior assistant. (e) This section shall become operative July 1, 2008.

12529.6. (a) The Legislature finds and declares that the Medical Board of California, by ensuring the quality and safety of medical care, performs one of the most critical functions of state **government**. Because of the critical importance of the board's public health and safety function, the complexity of cases involving alleged misconduct by physicians and surgeons, and the evidentiary burden in the board's disciplinary cases, the Legislature finds and declares that using a vertical prosecution model for those investigations is in the best interests of the people of California. (b) Notwithstanding any other provision of law, as of January 1, 2006, each complaint that is referred to a district office of the board for investigation shall be simultaneously and jointly assigned to an investigator and to the deputy attorney general in the Health Quality Enforcement Section responsible for prosecuting the case if the investigation results in the filing of an accusation. The joint assignment of the investigator and the deputy attorney general shall exist for the duration of the disciplinary matter. During the assignment, the investigator so

assigned shall, under the direction of the deputy attorney general, be responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action. (c) The Medical Board of California, the Department of Consumer Affairs, and the Office of the Attorney General shall, if necessary, enter into an interagency agreement to implement this section. (d) This section does not affect the requirements of Section **12529**.5 as applied to the Medical Board of California where complaints that have not been assigned to a field office for investigation are concerned. (e) This section shall become inoperative on July 1, 2008, and, as of January 1, 2009, is repealed, unless a later enacted statute, that is enacted before January 1, 2009, deletes or extends the dates on which it becomes inoperative and is repealed. **12529**.7. By July 1, 2007, the Medical Board of California, in consultation with the Department of Justice, the Department of Consumer Affairs, the Department of Finance, and the Department of Personnel Administration, shall report and make recommendations to the Governor and the Legislature on the vertical prosecution model created under Section **12529.6**.

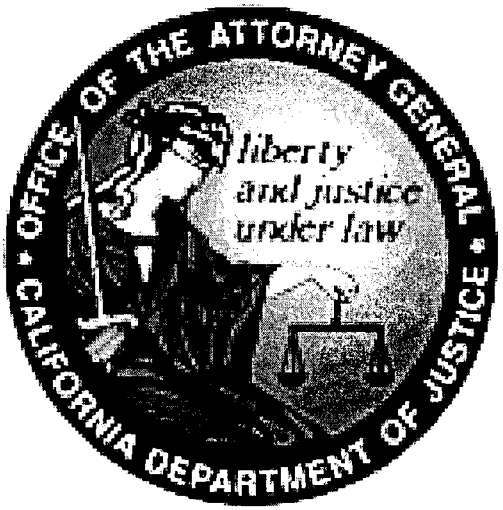
APPENDIX C

Vertical Prosecution Manual (Second Edition, November 2006)

Vertical Prosecution Manual

(Second Edition, November 2006)

Health Quality Enforcement Section
Office of the Attorney General
of the State of California
Medical Board of California



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Preface

November 20, 2006

On January 1, 2006, Senate Bill 231 (Figueroa) became effective, bringing with it a new level of cooperation and teamwork in the joint mission of the Medical Board of California (MBC) and Health Quality Enforcement Section (HQE) to protect the public health, safety and welfare of all Californians. While the bill itself contained a number of significant changes to both the investigation and prosecution of cases involving physicians, the most significant change was the Legislature's adoption of the "Vertical Prosecution Model" which, for the first time, brought investigators and deputy attorneys general together from the very start of the investigation through to its closure or, if warranted by the evidence, prosecution of the case.

Since January 1, 2006 the MBC and HQE have made great strides in implementing the Vertical Prosecution Model. New policies and procedures have been adopted by both agencies. Investigators and attorneys have begun working together from the very start of the investigations, additional deputies have been and continue to be hired so they can be readily available to investigators, new DOJ computers are being installed in the MBC District Offices to facilitate the use of ProLaw and efforts continue toward creating a shared database.

Vertical Prosecution is a pilot program. As such, it represents an opportunity for both HQE and the MBC to demonstrate the public protection benefits so that, at the end of the pilot program, the goal of transferring MBC investigators to the Department of Justice can be achieved. The realization of this important goal will require that HQE deputies and MBC investigators continue to work together as a single unit notwithstanding the fact that, during this pilot program, they remain employed by two separate agencies.

We have learned a great deal about how both agencies can further improve their level of cooperation and teamwork. The provisions of this Second Edition will govern the handling of vertical prosecution investigations and prosecutions by MBC investigators and HQE deputies. Our thanks to everyone for your hard work and dedication, and commitment to public protection.

Carlos Ramirez
Senior Assistant Attorney General
Health Quality Enforcement Section

Dave Thornton
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I. The Vertical Prosecution Team:

Vertical prosecution is based on the team concept with each member working together with other members to achieve the common goal of greater public protection for the people of California. The development of a cohesive and positive team based on respect for the vital roles played by each team member is critical to the success of this pilot program. The following is a description of the duties, responsibilities and vital roles of each member of the vertical prosecution team.

- Investigators develop and update investigative plans, conduct fair, impartial and thorough investigations and participate in the administrative hearing process, all under the supervision of their Supervising Investigators I and II, Deputy Chiefs, and Chief of Enforcement, and direction of the assigned Primary Deputy Attorney General.

- District Medical Consultants provide medical input and assistance through review of medical records, participation in subject interviews, selection of expert reviewers and evaluation of expert opinions, all under the supervision of their Supervising Investigators I and II, Deputy Chiefs, and Chief of Enforcement, and direction of the assigned Primary Deputy Attorney General.

- Supervising Investigators I supervise a staff of assigned investigators, medical consultants, investigator assistants and clerical staff to ensure the forward progression of the caseloads for which they are responsible. Supervising Investigators I are responsible for ensuring that cases are investigated in a timely and efficient manner and in conjunction with directions from the Primary Deputy Attorney General and that investigator support continues through the prosecution of the case when disciplinary charges are filed. Supervising Investigators I also complete monthly reports, monitor case progress through quarterly case reviews and handle personnel matters as necessary.

- Supervising Investigators II supervise a staff of Supervising Investigators I assigned to a geographical area and oversee the general operation of that area. Supervising Investigators II develop and implement board policy, are the first-line resolution attempt at the citation and fine informal conference, sign subpoenas duces tecum, develop, coordinate and implement training, handle complex personnel matters and act as a liaison with other government entities.

- Deputy Chiefs directly manage a staff of Supervising Investigators II, as well as the overall enforcement operations program, including training, internal affairs, background investigations and probation.

- The Chief of Enforcement supervises the Deputy Chiefs and manages the overall enforcement program to facilitate its efficient operation.

- Primary Deputy Attorneys General work closely with other team members and, in conjunction with Supervising Investigators I, direct investigators in the obtaining of evidence. Primary Deputy Attorneys General provide legal advice to the client and prosecute the case when disciplinary charges are filed.

- Lead prosecutors are assigned to specific Board district offices, act as the principal liaison to that office, are jointly assigned with another deputy on each case, act as the Primary Deputy Attorney General when so assigned and, when not so assigned, continue to monitor the progress of the investigation and appropriateness of directions from the Primary Deputy Attorneys General.

- Supervising Deputy Attorneys General supervise and provide support for their Deputy Attorneys General, oversee and monitor investigations within their respective geographical areas, and supervise the prosecution of cases when disciplinary charges are filed.

- Senior Assistant Attorney General, HQE, in conjunction with the Executive Director of the Medical Board, oversees and bears responsibility for all investigations and prosecutions within the jurisdiction of the Board's Enforcement Program.

II. Vertical Prosecution Under Senate Bill 231:

The three principle elements of the "vertical prosecution model" can be briefly summarized as follows:

1. Each physician and surgeon complaint referred to a district office of the board for investigation shall be simultaneously and jointly assigned to an investigator and to the deputy attorney general in the Health Quality Enforcement Section responsible for prosecuting the case if the investigation results in the filing of an accusation.

2. The joint assignment of the investigator and the deputy attorney general shall exist for the duration of the disciplinary matter.[1]

3. During the assignment, the investigator so assigned shall, under the direction of the deputy attorney general, be responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action. (Gov. Code, § 12529.6.)

While the Legislature has expressly limited the mandatory use of the "vertical prosecution model" to cases involving physicians and surgeons (Gov. Code, § 12529.6, subd. (a)), HQE and the Medical Board have determined that it shall be used in cases involving all licensees and applicants within the jurisdiction of the Board, except criminal cases.

III. Cooperation and Consultation in Direction and Supervision:

The fundamental purpose underlying the vertical prosecution pilot program is to bring investigators and deputy attorneys general together from the beginning of an investigation in order to improve coordination and teamwork, increase efficiency, and reduce investigation completion delays, all with the overall goal of increasing public protection. At the same time, however, it is important to recognize that the authority and responsibility to supervise investigators remains vested in Supervising Investigators I and II who continue to play an essential and vital role in both the Medical Board's Enforcement Program, as well as the success of this pilot program.

It is vitally important that Supervising Investigators I and II and deputy attorneys general cooperate and consult with each other in order to provide consistent, clear instructions to investigators. By doing so, Supervising Investigators I and II and deputy attorneys general will not only help achieve the legislative goals underlying this vertical prosecution pilot program but, at the same time, help reduce instances where an investigator is unsure whom he/she works for or feels torn between two sets of inconsistent instructions.

In exercising the statutory authority of direction under Government Code section 12529.6, deputies should be careful not to do so in a manner that undermines the supervision authority of Supervising Investigators I and II. Likewise, Supervising Investigators I and II should be careful not to exercise their supervision authority in an manner that undermines the direction authority of deputy attorneys general. Cooperation and consultation are the keys to ensuring these expectations are met.

IV. Direction of Investigation:

Teamwork is an essential component of the Legislature's new "Vertical Prosecution Model" which brings investigators and deputy attorneys general together from the very beginning of an investigation through closure or completion of the prosecution. The shared goal of both the Board and HQE in implementing the Legislature's new "Vertical Prosecution Model" is to improve the quality of both investigations and prosecutions of cases involving alleged misconduct by licensees.

Variations of vertical prosecution are employed by many law enforcement agencies. Such models generally rely on a team concept that typically involves the joint assignment of an investigator and prosecuting attorney, the latter with responsibility and authority to direct the investigator in the accumulation of evidence necessary to evaluate and, if violations of law are discovered, prosecute the case. The "Vertical Prosecution Model" enacted by the Legislature in Senate Bill 231 is such a model with the single notable exception that, here, the investigators are employed by the Board and the attorneys by the California Department of Justice. Prior to the enactment of Senate Bill 231, investigators worked at the direction of their Supervising Investigators I and II, Deputy Chiefs, and the Chief of Enforcement, when conducting an investigation. However, effective January 1, 2006, Senate Bill 231 requires that investigators work at the direction of their jointly assigned deputy attorney general. (Gov. Code, § 12529.6, subd. (b).)

"Direction," as that term is used in section 12529.6, includes, but is not limited to, the authority and responsibility to direct the assigned investigator to complete investigative tasks,

obtain required testimonial and documentary evidence, make periodic reports regarding the progress of the investigation, and complete additional tasks necessary to prepare and present the case for hearing.[2] Such authority and responsibility also includes setting investigative priorities in conjunction with the Supervising Investigator I, monitoring the progress of the investigation to ensure its completion in a timely and efficient manner, determining when an investigation should be closed as well as when an investigation is completed such that the case is appropriate for acceptance by HQE for prosecution.

Investigators continue to work under the supervision of the Supervising Investigator I of the District Office.[3] It is anticipated that Supervising Investigators I and II, Deputy Chiefs, and the Chief of Enforcement will assist in ensuring that investigators complete investigative assignments, as directed by the assigned deputy attorney general, in a timely and efficient manner.

While the passage of Senate Bill 231 represents a significant change with regard to who makes the ultimate determination regarding the manner, extent and duration of each investigation, as a practical matter, deputy attorneys general and Board investigators will continue to work as a strong team with each member contributing his or her own unique talents to the investigation and prosecution of physician disciplinary matters.

V. Lead Prosecutor:

As part of the implementation of Senate Bill 231, the new position of Lead Prosecutor has been created. One Lead Prosecutor shall be assigned to each of the Board's District Offices.[4] The Lead Prosecutor shall be physically present at the assigned District Office to the extent that it is necessary to fully discharge his or her responsibilities, as described herein.

The Lead Prosecutor shall be assigned to, and shall review, each complaint referred to the District Office for investigation. In addition to the Lead Prosecutor, a second deputy attorney general shall be assigned by the Supervising Deputy Attorney General to each complaint as well. The Lead Prosecutor shall act as the primary deputy attorney general on the case for all purposes until and unless replaced by the second deputy attorney general, as described below.

An investigator shall be jointly assigned to the case by his or her Supervising Investigator, in consultation with the Lead Prosecutor. The investigator shall work with, and at the direction of, the Lead Prosecutor as the primary deputy attorney general on the case.

The Lead Prosecutor shall determine whether the complaint warrants further investigation or whether it should be closed without further investigation. If the Lead Prosecutor determines an investigation should be closed without further investigation, he or she should consult with the Supervising Investigator I. Disputes regarding whether a complaint merits further investigation should be handled in accordance with Section XXII, below.

If the Lead Prosecutor determines that the complaint warrants further investigation, he or she will so inform the assigned investigator who, in turn, shall prepare a plan of investigation. (See Section VII, below.) Except as noted below, the Lead Prosecutor shall review and approve, with or without modifications, the original plan of investigation submitted by the assigned investigator.

In some cases, the Lead Prosecutor will function as the primary deputy attorney general throughout the investigation and prosecution of the case. Whenever the Lead Prosecutor determines, either upon review of the original complaint or as the investigation progresses, that it is a likely a violation of law may be found, the second deputy attorney general shall replace the Lead Prosecutor as the primary deputy attorney general on the case for all purposes. The Lead Prosecutor will promptly notify the assigned investigator and his or her Supervising Investigator I, in writing, of any such transfer of primary responsibility. Copies of this new assignment shall be sent to the Supervising Deputy Attorney General, Supervising Investigator II, Deputy Chiefs and Chief of Enforcement. Following transfer of responsibility, the Lead Prosecutor shall continue to monitor the progress of the investigation and appropriateness of directions from the primary deputy attorney general.

It is anticipated that the second deputy attorney general shall immediately become the primary deputy attorney general in all cases involving allegations of sexual abuse or misconduct, mental or physical illness affecting competency to practice medicine, and complex criminal conviction cases.

VI. Receipt of Complaint and Assignment of Staff:

Upon receipt of a complaint from the Central Complaint Unit, the Supervising Investigator I will review and assign the complaint. The supervisor will enter the assigned investigator name into the CAS system. The Supervising Investigator I will notify the Lead Prosecutor of the assignment and provide the Lead Prosecutor with a hard or electronic copy of the complaint.

The Lead Prosecutor will enter the case into ProLaw and assign him or herself as the primary deputy attorney general, except for complaints involving sexual abuse or misconduct, mental or physical illness affecting competency to practice medicine, and complex criminal conviction cases. The Lead Prosecutor will insert in the Prolaw "Notes" tab (second tab in the Matters module), under the SYNOPSIS, the following additional information regarding the case: (a) the name of the investigator assigned to the case; (2) whether the case is appropriate for an ISO or other pre-accusation relief; and (3) any other information the Lead Prosecutor determines is significant. The Lead Prosecutor will then send an e-mail which includes all of the information in the Notes Tab to the Supervising Deputy Attorney General and Supervising Investigator I.

The Supervising Deputy Attorney General will assign a second deputy attorney general to the case. Even though a second deputy is assigned, the Lead Prosecutor will remain as the "primary" on the case, i.e., the deputy responsible at any given time for the direction of the investigation. However, when it appears likely that the investigation will result in the filing of an accusation, a petition for pre-accusation relief or a civil action, or when the investigation involves allegations of sexual abuse or misconduct, mental or physical illness affecting competency to practice medicine or criminal conviction cases in a complex matter, the second deputy will be made the "primary." While the Lead Prosecutor will remain assigned to the case and will continue to monitor the case, only the primary deputy attorney general will direct the investigation.

The Supervising Deputy Attorney General will send an e-mail to the Lead Prosecutor, second DAG, and Supervising Investigator I notifying them that the case has been assigned and identifying who shall be the primary deputy on the case. If and when the primary deputy changes from the Lead Prosecutor to the second deputy, the Supervising Deputy Attorney General will send an e-mail to the investigator notifying him or her of the change and copy the Lead Prosecutor and the Supervising Investigator I.

The Supervising Deputy Attorney General will send an e-mail to his or her secretary with instructions to open the physical investigative file and to deliver that file to the primary deputy on the case. The secretary will deliver the physical investigative file to the primary deputy.

The Supervising Investigator I will enter the primary deputy attorney general assignment into the CAS Supervisor Notebook.

VII. Investigation Plan and Progress Report:

Each investigation shall begin with the development and approval of a plan of investigation. The plan shall be updated as significant events occur, as tasks are completed, and as the plan is changed. While it is expected that the primary deputy attorney general and investigator will regularly discuss all aspects of the case, all updates and changes to the plan are to be documented as provided below.

Within five (5) business days of an initial assignment of an investigation, the assigned investigator shall prepare, and submit to the primary deputy attorney general for review and approval, a proposed plan of investigation.[5]

In preparing the initial IPPR, the assigned investigator, should discuss the proposed investigative plan with his/her Supervising Investigator I, as necessary. The initial IPPR should contain the steps the investigator believes are most appropriate for the timely and efficient investigation of the case. Upon completion, the initial IPPR should be submitted by the assigned investigator to the primary deputy attorney general electronically as an e-mail attachment, with a copy sent to the Lead Prosecutor and Supervising Investigator I.

Within five (5) business days of receipt of the initial IPPR, the primary deputy attorney general shall review and approve the plan, with or without required changes or modifications, by way of a reply e-mail sent to the assigned investigator and copied to the Supervising Investigator I, Lead Prosecutor (if not the primary) and Supervising Deputy Attorney General. The primary deputy attorney general shall insure that a copy of the initial approved IPPR is placed in the Attorney General's ProLaw program.

The investigation is to be conducted pursuant to the IPPR. The assigned investigator and primary deputy attorney general should discuss proposed changes or modifications to the initial IPPR, as necessary and, if approved by the primary deputy attorney general, such changes or modifications should be confirmed in writing by e-mail.

The assigned investigator and primary deputy attorney general shall maintain a running e-mail thread, replying and communicating to each other by adding information to the e-mail thread as the investigation progresses which will then serve as ongoing documentation of

the progress of the investigation. The primary deputy attorney general is charged with the responsibility of maintaining a copy of that running e-mail thread in the Attorney General's ProLaw program.[6]

As the investigation progresses, significant events occur and investigative tasks are completed, the assigned investigator shall keep the primary deputy attorney general informed by way of the running e-mail thread.

The assigned investigator shall inform the primary deputy attorney general in writing, by way of the running e-mail thread, of the dates of significant witness interviews, including the initial physician interview. The primary deputy attorney general shall notify the investigator if he or she will be participating in an interview. If so, the primary deputy attorney general, assigned investigator and District Medical Consultant (if he or she will be present for interview) should discuss the topics each will cover during the interview.

Finally, primary deputy attorneys general and investigators are reminded of the importance of sending copies of the initial IPPR and subsequent IPPR e-mails to both the Lead Prosecutor and Supervising Investigator I. This is essential since they are charged with insuring the overall efficient operation and timely completion of the investigation.

VIII. Documentation of Significant Communications:

All significant communications between the primary deputy attorney general and assigned investigator shall be reduced to writing by the originator of the communication. In addition to the initial IPPR and subsequent IPPR e-mails, it is recommended that these communications be documented by e-mail. Copies of all such e-mails shall be maintained by the primary deputy attorney general in the investigation case file. Documenting such significant communications will help avoid misunderstandings and allow Lead Prosecutors, Supervising Investigators and Supervising Deputy Attorneys General to monitor the progress of investigations.

IX. Investigation Reports:

Investigation reports are to be kept current. The investigator should keep the report of investigation current and record all events as soon as possible, and preferably no more than five (5) business days following the event.

X. Periodic Review of Ongoing Investigations:

The primary deputy attorney general and assigned investigator, and the Supervising Investigator I as necessary, should participate in the periodic review of ongoing investigations. While it is preferable that such reviews take place in person, participation electronically is permitted where necessary.

A case review, including the District Medical Consultant whenever possible, shall take place prior to referral of the matter to an expert. This review should, whenever possible, be conducted in person and include a review by the primary deputy attorney general of the

investigation report and attachments. The primary attorney shall also insure the chosen expert is an appropriate expert to review the case, taking into consideration the expert's board certification and area of current active practice. Documents provided to the expert shall comply with the relevant provisions of the Board's Enforcement Operations Manual. Prior to submitting a case to an expert reviewer, the investigator should reference the Standards for Case Submission to Expert Reviewer (EOM section 7.4).

The assigned investigator should promptly provide a copy of the initial expert report to the primary deputy attorney general and District Medical Consultant. The primary deputy attorney general, District Medical Consultant and assigned investigator should determine whether all relevant matters have been reviewed and addressed by the expert, whether clarification of the expert's initial opinions and conclusions is needed, and whether additional further investigation (e.g., a second physician's interview) is required. After receipt of the initial expert report, the primary deputy attorney general is also strongly encouraged to consult with the District Medical Consultant to make this determination. If additional further investigation is required, the primary deputy attorney general shall inform the assigned investigator in writing, preferably by e-mail, with copies of that e-mail being sent to the investigator's Supervising Investigator I, Lead Prosecutor and Supervising Deputy Attorney General.

XI. Witness Interviews:

Throughout the course of the investigation, the primary deputy attorney general may elect to participate in witness interviews including the physician's interview. The primary deputy attorney general shall advise the assigned investigator if he or she will be participating in any witness interview. In such cases, prior to the commencement of the interview, the primary deputy attorney general should discuss the topics each will cover during the interview. If the District Medical Consultant will be present for the interview, he or she should be included in the pre-interview discussion as well.

XII. Pagination of the Investigation Material Before Transmittal to Expert:

Prior to transmittal of the investigation material to an expert for review, the assigned investigator, or his or her designee, shall paginate the investigation material. Page numbers shall be affixed to the investigation material in such a fashion as not to obscure any of the written information contained thereon. When referring to particular documents in the investigation material, the expert reviewer shall refer to specific page numbers in his or her expert report.

As of the date of the publication of this Second Edition of Vertical Prosecution Manual, the Medical Board does not presently have sufficient investigation support staff to paginate the investigation material as provided in this section. It is anticipated that, once sufficient investigation support staff have been retained by the Medical Board, the pagination of investigation material described in this section will be done prior to transmittal to an expert for review.

XIII. Acceptance of Cases for Prosecution:

Within five (5) business days of submission of the completed investigation, the primary deputy attorney general shall determine whether the case will be closed or accepted. If

accepted for prosecution, the primary deputy attorney general shall communicate his or her acceptance of the case in writing by way of running e-mail thread which shall be sent to the assigned investigator, the Supervising Investigator I, the Lead Prosecutor and the Supervising Deputy Attorney General. The acceptance of the case by the primary deputy attorney general does not preclude the possibility that further investigation may be required.

XIV. Content of Investigation File:

Upon acceptance of the case by the primary deputy attorney general, the assigned investigator should deliver a copy of the entire investigation file, along with a memorandum documenting acceptance, to the Lead Prosecutor for delivery to the appropriate Supervising Deputy Attorney General. The entire investigation file shall consist of all documents related to the case, regardless of relevancy and regardless of the place where they are maintained (e.g., master file, investigator's copy of the file, or any other file, formal or not) beginning with and including the original complaint and related documents initially received by the District Office from the Board's Central Complaint Unit.

XV. Approval of Proposed Closure of Investigation:

In cases in which the report of investigation recommends closure, the primary deputy attorney general shall, within ten (10) business days, review the proposed closure and indicate either approval or disapproval. Any failure to comply with this time limitation shall be brought to the attention of the Supervising Deputy Attorney General.

If, at any stage in the investigation, the primary deputy attorney general concludes the investigation should be closed, he or she shall submit a proposal to close the investigation to the Lead Prosecutor by e-mail, with a copy of that e-mail being simultaneously sent to the assigned investigator, the Supervising Investigator I, and Supervising Deputy Attorney General. Within ten (10) business days, the Lead Prosecutor shall review the proposed closure and indicate in writing either approval or disapproval of the proposal. Any failure to comply with this time limitation shall be brought to the attention of the Supervising Deputy Attorney General. If approved, the Lead Prosecutor shall send notification of the case closure to the primary deputy attorney general, assigned investigator, and Supervising Investigator I. If disapproved, the Lead Prosecutor shall indicate in writing any additional investigative tasks that shall be completed.

If the Lead Prosecutor is the primary deputy attorney general at the time of the proposed closure, he or she shall close the case and notify, by e-mail, the assigned investigator, Supervising Investigator I, and Supervising Deputy Attorney General, of the closure. Disagreements regarding proposed closures of investigations shall be resolved as described in Section XXII, below.

XVI. Submission of Proposed Accusations for Filing:

The primary deputy attorney general should submit a proposed Accusation for filing to the Executive Director of the Board within thirty (30) calendar days of acceptance of the case for prosecution.

XVII. Filing of Requests to Set with the Office of Administrative Hearings:

Within fifteen (15) calendar days of receipt of the Notice of Defense, the primary deputy attorney general shall submit a request to set to the Office of Administrative Hearings.

XVIII. Subpoena Review and Enforcement:

Prior to issuance, all subpoenas requesting document production shall be supported by declarations which demonstrate that the particular records sought are relevant and material to the investigation. The declaration should be factually sufficient to permit a reviewing court to independently make a finding of good cause to order the documents disclosed. Within ten (10) business days after the determination that a subpoena will be necessary to compel document production, the assigned investigator shall submit the subpoena and supporting declaration for review and approval by the primary deputy attorney general. Preparation of the subpoena and supporting declaration shall be the responsibility of the assigned investigator. Subpoena enforcement actions shall be the responsibility of the primary deputy attorney general and shall be filed in the appropriate court within thirty (30) business days of acceptance of the subpoena enforcement request.

XIX. Interim Orders of Suspension and Penal Code Section 23 Appearances:

The Lead Prosecutor shall identify those cases in which an Interim Order of Suspension ("ISO") or Penal Code section 23 ("PC 23") appearance is necessary and shall so notify the Supervising Deputy Attorney General. In such cases, the Supervising Deputy Attorney General shall designate the second deputy attorney general as the primary deputy attorney general who shall be responsible for obtaining any necessary ISO or making any necessary PC 23 appearance. The Supervising Deputy Attorney General shall notify the assigned investigator, Lead Prosecutor, and Supervising Investigator I of such designations.

XX. Petitions for Competency, Physical and Mental Examinations:

The primary deputy attorney general shall be responsible for preparing and filing petitions for competency, physical and mental examinations.

XXI. Administrative Hearings:

After the filing of an Accusation, there are often additional investigative tasks that must be completed in order to prepare a case for an upcoming administrative hearing. When additional investigation is required post-accusation to prepare for, or present the case at, the administrative hearing, the primary DAG will notify the assigned investigator of the required additional investigation by e-mail, with a copy to the Supervising Investigator I, Lead Prosecutor (if not the primary) and Supervising Deputy Attorney General.

The assigned investigator is expected to attend the administrative hearing unless the primary deputy attorney general, in consultation with the Supervising Investigator I and Supervising Deputy Attorney General, releases the investigator. While such attendance necessarily takes time away from the investigator's other cases, the investigator's attendance and

participation at the administrative hearing will ultimately benefit the prosecution of the case and the investigations and prosecutions of future cases.

XXII. Disagreements:

Occasionally, a disagreement may arise between an assigned investigator and primary deputy attorney general regarding an investigation. Whenever this occurs, the assigned investigator should first discuss his or her concerns directly with the primary deputy attorney general in an effort to resolve the disagreement. If the disagreement remains unresolved, the assigned investigator and primary deputy attorney general should discuss the matter with the Lead Prosecutor, Supervising Investigator I and/or Supervising Investigator.II. If the disagreement remains unresolved, the matter shall be submitted to the Supervising Deputy Attorney General who, after consultation with the Chief of Enforcement, shall issue a determination.

It is the expectation of both the Senior Assistant Attorney General and the Executive Director of the Medical Board that, in the vast majority of cases, the determination of the Supervising Deputy Attorney General will resolve the disagreement. If, however, the disagreement remains unresolved, it shall be submitted to the Senior Assistant Attorney General who, after consultation with the Chief of Enforcement and the Executive Director of the Medical Board, shall issue a final determination.

XXIII. Statistical Measure of Efficiency of the Vertical Prosecution Model:

In addition to any other statistical measure that may be later identified, one statistical measure that shall be used to assess the efficiency of the vertical prosecution model, as described in Senate Bill 231, shall be the length of time from receipt by the Board's District Office of the original complaint from the Board's Central Complaint Unit to the date that the investigation is closed or a Request to Set is submitted to the Office of Administrative Hearings. Both Board investigators and HQE deputy attorneys general are jointly responsible for this statistical measure of efficiency. In its early stages, it is anticipated that use of the "vertical prosecution model" may extend the time it takes to complete some investigations.

XXIV. Implementation of the "Vertical Prosecution Model" with Existing Staff:

It is important to recognize that both the Board and HQE are presently in the process of recruiting, hiring and training additional personnel to fully implement the Vertical Prosecution Model contained in Senate Bill 231. This is a continuing process and, as the Board and HQE become fully staffed, there will be a far greater likelihood that the legislative goals of efficiency and enhanced public protection which underlie Senate Bill 231 will be achieved.

XXV. Future Revisions to this Manual:

It is anticipated that this "Vertical Prosecution Manual (Second Edition, November 2006)" will undergo future revisions and refinements as HQE and the Board continue on their joint mission to protect the public health, safety and welfare.

Endnotes:

1. Case reassignments, which are a routine occurrence in any law enforcement agency, including HQE, are necessitated for any number of reasons. For example, a case may be reassigned as a result of the illness or death of a deputy, the transfer of a deputy to another section or his/her termination of employment with the Attorney General's Office, the hiring of a new HQE deputy, a maternity leave, conflict of interest, and also for purposes of managing the case load of both individual deputies and the HQE section statewide. Likewise, an investigation may be reassigned from one investigator to another for similar reasons as well. While the presumption is that an original joint assignment will be maintained throughout the duration of a disciplinary matter, appropriate case reassignments will be made when necessary to insure the efficient, thorough and timely investigation and prosecution of cases.

2. The word "direction" has been defined as "[t]he act of governing; management; superintendence" (Black's Law Dictionary, 4th ed. (1968) at p. 547, col. 1) and "[t]hat which is imposed by directing; a guiding or authoritative instruction; order; command" (*Id.*). The word "superintend" means "[t]o have charge and direction of; to direct the course and oversee the details; to regulate with authority; to manage; to oversee with the power of direction; to take care of with authority." (*Id.*, at p. 1606, col. 1; cf. Gov. Code, § 12529.5, subd. (b) ["The Senior Assistant Attorney General and deputy attorneys general working at his or her direction . . ."].)

3. The word "supervise" has been defined as "[t]o have general oversight over, to superintend or to inspect." (Black's Law Dictionary, 4th ed. (1968) at p. 1607, col. 1.) The word "superintend" means "[t]o have charge and direction of; to direct the course and oversee the details; to regulate with authority; to manage; to oversee with the power of direction; to take care of with authority." (*Id.*, at p. 1606, col. 1.)

4. Until such time as HQE is fully staffed with a sufficient number of attorneys, it may be necessary for a Lead Prosecutor to be assigned to more than one of the Board's district offices.

5. In the vast majority of cases, the primary deputy attorney general shall be the Lead Prosecutor assigned to the District Office where the assigned investigator works.

6. This can be accomplished either by dropping and dragging updated copies of the entire e-mail thread into the ProLaw matter or by cutting and pasting the entirety of the e-mail thread text into the Case Diary in the matter.

MEDICAL BOARD OF CALIFORNIA BUDGET OVERVIEW BY BOARD COMPONENT

	EXEC	ENFORCE	LICENSING	ADMIN SERVICES	DIVERSION	INFO SYSTEMS	PROBATION MONITORING	BOARD TOTAL
FY 03/04								
$ Budgeted	1,577,000	26,305,000	3,322,000	1,742,000	1,057,000	2,572,000	1,895,000	38,470,000
$ Spent*	1,372,000	25,799,000	3,231,000	1,788,000	1,029,000	2,228,000	1,031,000	36,478,000 *
Positions								
Authorized	8.0	143.6	37.2	20.0	11.0	15.0	18.0	252.8
FY 04/05								
$ Budgeted	1,504,000	28,428,000	3,482,000	1,750,000	1,194,000	2,548,000	2,117,000	41,023,000
$ Spent *	1,419,000	27,264,000	3,151,000	1,774,000	1,054,000	2,298,000	1,340,000	38,300,000 *
Positions								
Authorized	8.0	137.6	37.2	20.0	12.0	15.0	23.0	252.8
FY 05/06								
$ Budgeted	1,531,000	29,371,000	3,567,000	1,814,000	1,189,000	2,711,000	2,399,000	42,582,000
$ Spent *	1,412,000	26,380,000	3,170,000	1,756,000	1,148,000	2,438,000	1,406,000	37,710,000 *
Positions								
Authorized	8.0	137.6	37.2	20.0	12.0	15.0	23.0	252.8
FY 06/07								
$ Budgeted	1,534,000	34,293,000	3,949,000	3,089,000	1,747,000	2,857,000	2,591,000	50,060,000
$ Spent thru 5/31*	1,352,000	28,226,000	3,221,000	2,594,000	1,248,000	2,210,000	1,350,000	40,201,000 *
Positions								
Authorized	8.8	141.6	40.5	19.4	14.0	16.0	25.0	265.3

* net expenditures (includes unscheduled reimbursements)

0758 - Medical Board
Analysis of Fund Condition

(Dollars in Thousands)

		ACTUAL 2005-06	2006-07	2007-08
BEGINNING BALANCE		$ 8,541	$ 12,128	$ 11,176
Prior Year Adjustment		$ 150	$ -	$ -
Adjusted Beginning Balance		$ 8,691	$ 12,128	$ 11,176
REVENUES AND TRANSFERS				
Revenues:				
125600	Other regulatory fees	$ 311	$ 363	$ 349
125700	Other regulatory licenses and permits	$ 5,143	$ 5,571	$ 5,571
125800	Renewal fees	$ 36,147	$ 41,637	$ 42,036
125800	"Revenue Neutral" Renewal fees		$ 400	$ 800
125900	Delinquent fees	$ 79	$ 100	$ 92
141200	Sales of documents	$ -	$ -	$ -
142500	Miscellaneous services to the public	$ 32	$ 35	$ 35
150300	Income from surplus money investments	$ 566	$ 219	$ 193
160400	Sale of fixed assets	$ -	$ 5	$ 5
161000	Escheat of unclaimed checks and warrants	$ 13	$ -	$ -
161400	Miscellaneous revenues	$ 6	$ 3	$ 3
164300	Penalty assessments - Probation Monitoring	$ -	$ 800	$ 800
Totals, Revenues		$ 42,297	$ 49,133	$ 49,884
Transfers to T03040	Medically Underserved Account per Chapter 1131, Statutes of 2002	$ (1,150)		
Totals, Revenues and Transfers		$ 41,147	$ 49,133	$ 49,884
Total Resources		$ 49,838	$ 61,261	$ 61,060
EXPENDITURES				
0840 State Controller (State Operations)			$ 25	$ 37
1110 Program Expenditures (State Operations)		$ 37,710	$ 50,060	$ 51,203
Total Expenditures and Expenditure Adjustments		$ 37,710	$ 50,085	$ 51,240
FUND BALANCE				
Reserve for economic uncertainties		$ 12,128	$ 11,176	$ 9,820
Months in Reserve		2.9	2.6	2.3

NOTES:

A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED.

B. EXPENDITURE GROWTH PROJECTED AT 2% BEGINNING FY 2008-09.

6/27/2007

Medical Board of California

FY 06/07
Budget Expenditure Report
(As of May 31, 2007)
(91.7% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB YTD 5/31/2007	PERCENT OF BUDGET EXP/ENCUMB	FISCAL YEAR EXPENDITURE PROJECTIONS	UNENCUMB BALANCE 6/30/07
PERSONAL SERVICES					
Salary & Wages					
(Staff & Exec Director)	14,912,628	12,132,188	81.4	13,220,000	1,692,628
DEC	24,000	22,000	91.7	28,000	(4,000)
Board Members	31,500	31,100	98.7	35,000	(3,500)
Phy Fitness Incentive Pay	29,623	24,895	84.0	30,000	(377)
Temp Help	1,144,410	1,036,016	90.5	1,280,000	(135,590)
Proctors	0	113		113	(113)
Overtime	12,143	56,501	465.3	75,000	(62,857)
Staff Benefits	6,191,598	5,049,644	81.6	5,468,000	723,598
Salary Savings	(1,006,512)				(1,006,512)
TOTALS, PERS SERVICES	21,339,390	18,352,457	86.0	20,136,113	1,203,277
OPERATING EXP & EQUIP					
General Expense	732,769	292,867	40.0	400,000	332,769
Minor Equipment	164,300	213,920	130.2	300,000	(135,700)
Fingerprint Reports	373,448	340,689	91.2	380,000	(6,552)
Printing	777,587	413,122	53.1	500,000	277,587
Communications	528,698	265,866	50.3	340,000	188,698
Postage	413,084	280,150	67.8	345,000	68,084
Insurance	35,277	25,900	73.4	25,900	9,377
Travel In-State	390,383	258,807	66.3	360,000	30,383
Travel Out-of-State	3,600	1,998	55.5	3,000	600
Training	58,469	60,866	104.1	80,000	(21,531)
Facilities Operation (Rent)	3,002,789	2,789,166	92.9	2,825,000	177,789
Consult/Prof Services	1,191,310	968,515	81.3	985,000	206,310
Departmental Prorata	3,890,812	3,572,112	91.8	3,896,000	(5,188)
Consolidated Data Ctr (Teale)	532,215	195,029	36.6	250,000	282,215
Data Processing	98,762	82,188	83.2	150,000	(51,238)
Central Admin Svcs (Statewide Prorata)	1,376,086	1,376,086	100.0	1,376,086	0
Attorney General Services	12,419,270	10,233,055	82.4	12,419,270	0
Office of Administrative Hearings	1,551,595	1,114,982	71.9	1,200,000	351,595
Court Reporter Services	125,000	80,923	64.7	125,000	0
Evidence/Witness	1,557,983	999,220	64.1	1,350,000	207,983
Major Equipment	369,000	378,684	102.6	380,000	(11,000)
Vehicle Operation/Other Items	225,261	304,127	135.0	360,000	(134,739)
Memorandum of Costs/Tort Payments	0	12,517		12,517	(12,517)
TOTALS, OE&E	29,817,698	24,260,789	81.4	28,062,773	1,754,925
TOTALS, EXPENDITURES	51,157,088	42,613,246	83.3	48,198,886	2,958,202
Scheduled Reimbursements	(384,000)	(362,154)	94.3	(384,000)	0
Distributed Costs	(713,000)	(621,273)	87.1	(711,456)	(1,544)
NET TOTAL, EXPENDITURES	50,060,088	41,629,819	83.2	47,103,430	2,956,658
Unscheduled Reimbursements		(1,429,079)		(1,500,000)	
		40,200,740		45,603,430	

Budget Expenditure Report.xls
Date: July 10, 2007

ENFORCEMENT/PROBATION RECEIPTS
MONTHLY PROFILE: JULY 2004 - JUNE 2007

	Jul-04	Aug-04	Sep-04	Oct-04	Nov-04	Dec-04	Jan-05	Feb-05	Mar-05	Apr-05	May-05	Jun-05	FYTD Total
Invest Cost Recovery	102,644	60,947	101,408	126,230	71,547	72,447	94,496	80,686	52,192	75,178	77,229	103,835	1,018,839
*Invest Cost Recovery Ordered**	*143,820*	*65,468*	*62,808*	*148,632*	*15,716*	*102,255*	*120,647*	*90,516*	*116,579*	*157,344*	*115,315*	*55,645*	*1,194,745*
Criminal Cost Recovery	3,882	997	1,292	994	1,987	2,386	1,331	17,572	1,846	1,586	2,140	3,720	39,733
Probation Monitoring	14,369	11,545	33,461	26,811	110,127	73,194	230,128	185,859	30,603	74,102	19,035	29,392	838,626
Exam	2,243	490	3,159	1,937	4,765	1,453	122	1,481	179	517	3,448	4,723	24,517
Cite/Fine	3,950	850	1,000	0	4,050	4,200	1,500	2,850	8,750	0	0	9,750	36,900
MONTHLY TOTAL	127,088	74,829	140,320	155,972	192,476	153,680	327,577	288,448	93,570	151,383	101,852	151,420	1,958,615
FYTD TOTAL	127,088	201,917	342,237	498,209	690,685	844,365	1,171,942	1,460,390	1,553,960	1,705,343	1,807,195	1,958,615	

	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	Jan-06	Feb-06	Mar-06	Apr-06	May-06	Jun-06	FYTD Total
Invest Cost Recovery	50,749	89,190	48,074	92,811	64,158	51,605	79,797	44,058	32,282	51,377	25,267	12,829	642,197
*Invest Cost Recovery Ordered**	*43,797*	*49,467*	*140,574*	*46,665*	*75,155*	*72,133*	*59,294*	*11,500*	*29,500*	*10,000*	*0*	*0*	*538,085*
Criminal Cost Recovery	1,350	16,822	746	1,151	8,570	760	586	5,661	5,489	690	600	730	43,155
Probation Monitoring	36,707	14,612	7,909	46,661	97,709	111,055	239,827	229,080	31,782	41,281	33,624	27,579	917,826
Exam	2,611	825	4,057	11,997	4,111	360	3,936	2,089	602	2,713	1,793	4,600	39,694
Cite/Fine	1,350	1,450	0	5,175	9,100	175	4,150	7,900	3,850	850	5,300	5,000	44,300
MONTHLY TOTAL	92,767	122,899	60,786	157,795	183,648	163,955	328,296	288,788	74,005	96,911	66,584	50,738	1,687,172
FYTD TOTAL	92,767	215,666	276,452	434,247	617,895	781,850	1,110,146	1,398,934	1,472,939	1,569,850	1,636,434	1,687,172	

	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	FYTD Total
Invest Cost Recovery	21,173	30,787	19,692	22,508	22,790	10,741	26,503	7,092	13,901	18,577	11,148	6,739	211,651
*Invest Cost Recovery Ordered**	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Criminal Cost Recovery	450	704	57,971	1,100	840	373	1,213	750	100	10,200	18,704	2,689	95,094
Probation Monitoring	28,503	30,868	8,857	14,327	123,405	112,580	332,202	155,028	33,346	42,898	27,097	22,698	931,809
Exam	4,456	5,843	3,093	1,065	2,440	1,561	7,215	1,505	3,858	3,105	515	5,656	40,312
Cite/Fine	4,675	3,600	3,750	7,420	8,150	4,350	5,000	4,700	2,950	10,960	5,200	650	61,405
MONTHLY TOTAL	59,257	71,802	93,363	46,420	157,625	129,605	372,133	169,075	54,155	85,740	62,664	38,432	1,340,271
FYTD TOTAL	59,257	131,059	224,422	270,842	428,467	558,072	930,205	1,099,280	1,153,435	1,239,175	1,301,839	1,340,271	

**not included in monthly and FYTD totals*

excel:enfreceiptsmonthlyprofile.xls.revised 7/5/07.

NOTE: cost recovery shown ordered after 1/1/06 was ordered in stipulations prior to 1/1/06

Medical Board of California
Board Members' Expense Report
July 1, 2006 - May 31, 2007

	*Per Diem $**				*Travel Expenses**	*Total Mar-May*	***Total FYTD***
	MAR	APR	MAY	TOTAL			
DMQ							
Mr. Alexander	600	600	500	1,700	910.62	2,610.62	10,400.41
Dr. Aristeiguieta	0	0	0	0	312.36	312.36	1,993.83
Dr. Breall	0	0	0	0	0.00	0.00	628.00
Dr. Campisi	0	0	0	0	0.00	0.00	366.80
Dr. Chin	300	0	0	300	678.98	978.98	2,377.84
Dr. Corday	400	200	0	600	0.00	600.00	3,263.15
Dr. Duruisseau	100	300	300	700	110.68	810.68	4,362.43
Dr. Greenberg	0	0	0	0	0.00	0.00	760.80
Dr. Low	0	0	0	0	0.00	0.00	0.00
Dr. Moran	0	0	0	0	0.00	0.00	400.00
Dr. Moy	0	0	0	0	0.00	0.00	0.00
Ms. Rice	0	0	0	0	0.00	0.00	200.00
Dr. Salomonson	600	0	200	800	726.16	1,526.16	1,826.16
Dr. Wender	200	200	0	400	971.57	1,371.57	2,628.54
Ms. Yaroslavsky	0	0	0	0	0.00	0.00	0.00
Mr. Zerunyan	500	600	700	1,800	971.68	2,771.68	6,558.86
SUB TOTAL	2,700	1,900	1,700	6,300	4,682.05	10,982.05	35,766.82
LICENSING							
Dr. Bolton	400	0	0	400	319.01	719.01	3,111.63
Ms. Chang	0	0	0	0	0.00	0.00	0.00
Dr. Fantozzi	800	800	900	2,500	2,636.23	5,136.23	14,792.71
Dr. Gitnick	0	0	0	0	667.13	667.13	1,864.91
Dr. Gregg	300	0	200	500	461.02	961.02	4,015.04
Dr. Karlan	0	0	0	0	0.00	0.00	2,154.06
SUB TOTAL	1,500	800	1,100	3,400	4,083.39	7,483.39	25,938.35
BOARD TOTAL	4,200	2,700	2,800	9,700	8,765.44	18,465.44	**61,705.17**

*includes claims paid/submitted through June 22, 2007

Board Members Expense Report.xls
Date: June 27, 2007

MEDICAL BOARD OF CALIFORNIA
EXECUTIVE PROGRAM
BUDGET REPORT
JULY 1, 2006 - MAY 31, 2007

	FY 06/07 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	557,805	527,462	current
Staff Benefits	227,003	167,760	current
TOTAL PERSONAL SERVICES	784,808	695,222	
OPERATING EXPENSE & EQUIPMENT			
General Expense 1/	70,000	46,521	1-2
Fingerprint Reports	0	12	current
Printing	175,000	177,531	1-2
Communications	24,467	8,505	1-2
Postage	150,000	115,696	1-2
Travel In-State	89,180	75,788	1-2
Travel Out-of-State	0	0	current
Training	5,000	798	1-2
Facilities Operations 2/	65,000	60,733	current
Consultant & Professional Services	2,000	20,502	1-2
Attorney General	5,000	0	1-2
Departmental Services 3/	119,058	107,984	current
Data Processing	2,000	289	1-2
Central Administrative Services 4/	42,108	42,108	current
Minor Equipment	0	538	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	748,813	657,005	
TOTAL BUDGET/EXPENDITURES	**1,533,621**	**1,352,227**	

See footnotes on next page

6/20/07
g/admin/execbud.xls

1/ costs for employee relocation, miscellaneous office supplies, freight and drayage, General Services administration overhead (charges levied by the Department of General Services for purchase orders, contracts, traffic management, fleet administration, and confidential destruction; charges levied by the State Controller's Office for the processing of disability insurance claims, late payroll document costs; by EDD for unemployment insurance and by DPA Admininstration; charges levied by any other state agency for services provided not under contract), meetings and conferences, library purchases and subscriptions, photography, and office equipment rental, maintenance and repairs.

2/ rent, security, maintenance, facility planning, waste removal, purchase of building supplies and materials.

3/ Department of Consumer Affairs prorata assessments for support of the following:

   a/ Communications and Education Division
   b/ Consumer and Community Relations Division
   c/ Administrative & Information Services Division
   d/ Division of Investigation Special Operations Unit

4/ Charges for support of the State Personnel Board, Department of Finance, State Controller, State Treasurer, Legislature, Governor's Office, etc.

MEDICAL BOARD OF CALIFORNIA
INFORMATION SYSTEMS PROGRAM
BUDGET REPORT
JULY 1, 2006 - MAY 31, 2007

	FY 06/07 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	982,457	896,213	current
Staff Benefits	451,093	318,794	current
TOTAL PERSONAL SERVICES	1,433,550	1,215,007	
OPERATING EXPENSE & EQUIPMENT			
General Expense	37,900	15,415	1-2
Printing	15,000	1,928	1-2
Communications	20,020	12,886	1-2
Postage	5,255	512	1-2
Travel In-State	21,441	5,035	1-2
Training	17,745	16,042	1-2
Facililties Operations	149,000	118,353	current
Consultant/Professional Services	96,310	104,333	1-2
Departmental Services	222,086	198,330	current
Consolidated Data Centers (Teale)	532,215	195,029	current
Data Processing	74,762	73,639	1-2
Central Administrative Services	78,575	78,575	current
Major Equipment	7,500	18,124	1-2
Minor Equipment	152,300	158,520	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	1,430,109	996,721	
DISTRIBUTED COSTS	(6,918)	(1,540)	
TOTAL BUDGET/EXPENDITURES	**2,856,741**	**2,210,188**	

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MEDICAL BOARD OF CALIFORNIA
ADMINISTRATIVE SERVICES PROGRAM
BUDGET REPORT
JULY 1, 2006 - MAY 31, 2007

	FY 06/07 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	963,199	891,615	current
Staff Benefits	416,442	357,011	current
TOTAL PERSONAL SERVICES	1,379,641	1,248,626	
OPERATING EXPENSE & EQUIPMENT			
General Expense	257,884	73,746	1-2
Printing	25,000	15,153	1-2
Communications	74,886	16,638	1-2
Postage	11,131	1,685	1-2
Travel In-State	17,251	10,418	1-2
Training	3,000	750	1-2
Facilities Operations	931,000	926,565	current
Consultant & Professional Services	77,000	1,367	1-2
Departmental Services	240,049	223,725	current
Data Processing	2,000	269	1-2
Central Administrative Services	84,905	84,905	current
Vehicle Operations/Insurance/Other	2,226	2,669	1-2
Major Equipment	30,000	10,517	1-2
Minor Equipment	0	8,550	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	1,756,332	1,376,957	
DISTRIBUTED COSTS	(46,979)	(32,151)	
TOTAL BUDGET/EXPENDITURES	**3,088,994**	**2,593,432**	

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MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
BUDGET REPORT
JULY 1, 2006 - MAY 31, 2007

	FY 06/07 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	1,805,723	1,582,362	current
Staff Benefits	778,445	650,183	current
TOTAL PERSONAL SERVICES	2,584,168	2,232,545	
OPERATING EXPENSES & EQUIPMENT			
General Expense	43,960	14,837	1-2
Fingerprint Reports*	369,948	337,510	current
Printing	50,000	87,459	1-2
Communications	68,724	39,806	1-2
Postage	137,446	86,205	1-2
Travel In-State	16,312	14,927	1-2
Travel Out-of-State	2,100	0	1-2
Training	4,000	60	1-2
Facilities Operation	162,000	172,226	current
Consult/Professional Services	266,000	274,372	1-2
Departmental Services	306,898	278,606	current
Data Processing	2,000	2,159	1-2
Central Administrative Services	108,573	108,573	current
Attorney General	190,000	125,045	current
Evidence/Witness Fees	10,764	359	1-2
Major Equipment	40,000	19,526	1-2
Minor Equipment	0	2,278	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	1,778,725	1,563,948	
SCHEDULED REIMBURSEMENTS	(384,000)	(362,154)	
DISTRIBUTED COSTS	(29,642)	(22,231)	
TOTAL BUDGET/EXPENDITURES	**3,949,251**	**3,412,108**	
Unscheduled Reimbursements		(190,974)	
		3,221,134	

*Department of Justice invoices for fingerprint reports, name checks, and subsequent arrest reports

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MEDICAL BOARD OF CALIFORNIA
DIVERSION PROGRAM
BUDGET REPORT
JULY 1, 2006 - MAY 31, 2007

	FY 06/07 BUDGET	EXPEND/ ENCUMB YR-TO-DATE	PERCENT OF BUDGET EXP/ENCUMB	LAG TIME (MONTHS)
PERSONAL SERVICES				
Salaries & Wages	701,095	658,414	93.9	current
Staff Benefits	292,521	237,457	81.2	current
TOTAL PERSONAL SERVICES	993,616	895,871	90.2	
OPERATING EXPENSES & EQUIPMENT				
General Expense	40,921	22,074	53.9	1-2
Printing	10,000	5,282	52.8	1-2
Communications	21,276	12,186	57.3	1-2
Postage	5,255	1,673	31.8	1-2
Insurance	1,582	1,130	71.4	current
Travel In-State	72,055	59,220	82.2	1-2
Travel Out-of-State	0	0		current
Training	4,418	3,544	80.2	1-2
Facilities Operation	32,000	28,342	88.6	current
Consultant/Professional Services	300,000	0	0.0	current
Departmental Services	135,782	123,171	90.7	current
DP Maint/Supplies	2,500	85	3.4	1-2
Central Administrative Services	48,025	48,025	100.0	current
Major Equipment	56,750	32,014	56.4	current
Vehicle Operations	11,000	12,931	117.6	1-2
Minor Equipment	12,000	1,807	15.1	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	753,564	351,484	46.6	
TOTAL BUDGET/EXPENDITURES	**1,747,180**	**1,247,355**	71.4	

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6/20/2007

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
BUDGET REPORT
JULY 1, 2006 - MAY 31, 2007

	FY 06/07 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	8,723,881	7,399,232	current
Staff Benefits	3,416,074	2,821,990	current
TOTAL PERSONAL SERVICES	12,139,955	10,221,222	
OPERATING EXPENSE & EQUIPMENT			
General Expense/Fingerprint Reports	255,604	109,523	1-2
Printing	495,087	125,153	1-2
Communications	289,539	158,349	1-2
Postage	100,806	74,323	1-2
Insurance	27,819	18,984	current
Travel In-State	122,358	70,818	1-2
Travel Out-of-State	1,500	1,998	current
Training	19,806	22,183	1-2
Facililties Operations	1,622,789	1,451,723	current
Consultant/Professional Services	450,000	567,941	1-2
Departmental Services	2,665,505	2,462,499	current
Data Processing	15,000	5,747	1-2
Central Administrative Services	942,619	942,619	current
Attorney General 1/	12,224,270	10,108,010	current
OAH	1,551,595	1,114,982	1
Evidence/Witness Fees	1,482,651	956,471	1-2
Court Reporter Services	125,000	80,923	1-2
Major Equipment	223,500	298,502	1-2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	67	49,012	1-2
Vehicle Operations	167,194	197,272	1-2
Minor Equipment	0	30,553	1-2
Memorandum of Costs/Tort Payments	0	12,517	current
TOTAL OPERATING EXPENSES & EQUIPMENT	22,782,709	18,860,102	
DISTRIBUTED COSTS	(629,461)	(565,351)	
TOTAL BUDGET/EXPENDITURES	**34,293,203**	**28,515,973**	
Unscheduled Reimbursements		(289,855)	
		28,226,118	

1/See next page for monthly billing detail

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MEDICAL BOARD OF CALIFORNIA
ATTORNEY GENERAL EXPENDITURES - FY 06/07
DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)

		Number of Hours	Rate	Amount
July	Attorney Services	4,711.25	158.00	744,377.50
	Legal Assistant Services	225.00	101.00	22,725.00
	Auditor/Analyst Services	1.50	63.00	94.50
	Cost of Suit			651.40
				767,848.40
August	Attorney Services	5,706.25	158.00	901,587.50
	Legal Assistant Services	220.25	101.00	22,245.25
	Auditor/Analyst Services	3.50	63.00	220.50
	Cost of Suit			1,480.89
				925,534.14
September	Attorney Services	5,178.00	158.00	818,124.00
	Legal Assistant Services	269.25	101.00	27,194.25
	Auditor/Analyst Services	1.00	63.00	63.00
	Cost of Suit			5,486.10
				850,867.35
October	Attorney Services	5,433.50	158.00	858,493.00
	Legal Assistant Services	291.75	101.00	29,466.75
	Auditor/Analyst Services		63.00	0.00
	Cost of Suit			5,050.15
				893,009.90
November	Attorney Services	5,573.75	158.00	880,652.50
	Legal Assistant Services	217.25	101.00	21,942.25
	Auditor/Analyst	0.50	63.00	31.50
	Cost of Suit			2,041.59
				904,667.84
December	Attorney Services	5,156.50	158.00	814,727.00
	Legal Assistant Services	170.75	101.00	17,245.75
	Auditor/Analyst	1.00	63.00	63.00
	Cost of Suit			5,365.91
				837,401.66

Enforcement AG Expenditures July - December = 5,179,329.29

Revised 6/14/07

MEDICAL BOARD OF CALIFORNIA
ATTORNEY GENERAL EXPENDITURES - FY 06/07
DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)

January	Attorney Services	6,323.75	158.00	999,152.50
	Legal Assistant Services	241.25	101.00	24,366.25
	Auditor/Analyst	0.50	63.00	31.50
	Cost of Suit			8,925.86
				1,032,476.11
February	Attorney Services	5,524.50	158.00	872,871.00
	Legal Assistant Services	227.25	101.00	22,952.25
	Auditor/Analyst	2.50	63.00	157.50
	Cost of Suit			2,866.52
				898,847.27
March	Attorney Services	6,235.25	158.00	985,169.50
	Legal Assistant Services	262.50	101.00	26,512.50
	Auditor/Analyst Services	1.50	63.00	94.50
	Cost of Suit			6,261.47
				1,018,037.97
April	Attorney Services	5,766.75	158.00	911,146.50
	Legal Assistant Services	190.00	101.00	19,190.00
	Auditor/Analyst Services	75.00	63.00	4,725.00
	Cost of Suit			
				935,061.50
May	Attorney Services	6,421.25	158.00	1,014,557.50
	Legal Assistant Services	263.50	101.00	26,613.50
	Auditor/Analyst Services	49.00	63.00	3,087.00
	Cost of Suit			
				1,044,258.00
June	Attorney Services		158.00	0.00
	Legal Assistant Services		101.00	0.00
	Auditor/Analyst Services		63.00	0.00
	Cost of Suit			
				0.00

06/07 FYTD Total = 10,108,010.14

Revised 6/14/07
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MEDICAL BOARD OF CALIFORNIA
PROBATION MONITORING
BUDGET REPORT
JULY 1, 2006 - MAY 31, 2007

	FY 06/07 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	1,413,631	1,347,516	current
Staff Benefits	610,020	496,449	current
TOTAL PERSONAL SERVICES	2,023,651	1,843,965	
OPERATING EXPENSES & EQUIPMENT			
General Expense	30,000	13,919	1-2
Printing	7,500	616	1-2
Communications	29,786	17,496	1-2
Postage	3,191	55	1-2
Insurance	5,650	5,424	current
Travel In-State	51,785	22,599	1-2
Training	4,500	17,489	1-2
Facilities Operation	41,000	31,218	current
Departmental Services	201,434	177,797	current
Data Processing	500	0	1-2
Central/Administrative Services	71,281	71,281	current
Evidence/Witness Fees	64,568	42,390	1-2
Major Equipment	11,250	0	1-2
Minor Equipment	0	11,674	1-2
Vehicle Operations/Other Items	45,000	42,606	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	567,445	454,564	
TOTAL BUDGET/EXPENDITURES	**2,591,096**	**2,298,529**	
Unscheduled Reimbursements*		(948,250)	
		1,350,279	

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*no authority to spend

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6/20/2007

APRIL 2007 MEETING

13 Members responded – On all the ratings, the overall response average was that the Board members **agree** that they have the information necessary, the discussion items are relevant, enough time is allowed to discuss agenda items, and they feel they are open to public input.

Comments per item:

Board meeting packet:

- Consider packets online.
- Include "big picture" reports in advance for ample time for board review.

Committee meetings:

- Division of Licensing should meet at the same time as Division of Medical Quality.
- Discussion was given regarding increasing info needed for Diversion Committee-staff was very open.
- Keep discussion to relevant data.
- Feels rushed - depending on agenda, some might be structured with more or less time.
- Consider increasing time for Diversion Committee to 1 ½ hours.

Division meetings:

- A few items were presented at the last minute.
- Legislation off of agenda. If this is done at the board meeting, not sure that it needs to be agendized. More time needs to be given to discussion. Start at 8:30 instead of 8:00. How do we track and insert into current agenda/minute notes what isn't dealt with? Maybe highlight minutes then insert as a to-do list/not completed but work in progress so we don't lose direction. Also, announce public speaker's time available to speak.
- Would like to see more on evaluation and reports from board employees and areas where board oversees. For example, need more evaluation and oversight of PACE and probation. Work proactively on future problem areas such as prevention of medical errors and unlicensed practice of medicine.
- Could the Division of Licensing closed session meeting on the first day of the board meetings be moved to 8:30 concurrent with Panel A and Panel B?
- Consider emailing last minute additions.
- I do like the new format.

Lunch Presentation:

- Two members noted that they missed having this.

Full board meetings:

- 6pm is too late to have a board meeting go to.
- Topic on addiction medicine; team building activities.

Further comments:

- Would it be possible to have the Division of Licensing, Panel A, and Panel B meeting concurrently on Thursday a.m., finishing up Thursday p.m. for more full board or follow-up on strategic planning?
- More structure and knowledge of timing of meetings so not so much lag time, i.e., 4pm or at the conclusion of Division of Licensing.
- Tables so we can see each other better.
- Introduce staff from each department at the end of meetings.
- The Division of Licensing had a closed session which allowed the Division of Medical Quality free time. Can the schedule change so that the Division of Medical Quality meets during the Division of Licensing Meeting?
- I like the new format.
- It worked!
- Great change!

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
EXECUTIVE OFFICE
1434 Howe Avenue, Suite 92
Sacramento, CA 95825-3236
(916) 263-2389 FAX (916) 263-2387
www.mbc.ca.gov

AGENDA ITEM 7C

July 5, 2007

To: Members,
Medical Board of California

From: Dave Thornton
Executive Director

Subject: Proposed 2008 Meeting Dates

The following meeting dates for 2008 are being provided at this time to allow Board members and interested parties with as much advanced planning time as possible.

The following locations and dates are proposed for your review:

Los Angeles	January 31, February 1, 2008
Sacramento	May 1, 2, 2008
San Francisco	July 24, 25, 2008
San Diego	November 6, 7, 2008

These dates will be put forward for adoption at the July Board meeting.

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
MEDICAL BOARD OF CALIFORNIA– Executive Office
1434 Howe Avenue, Suite 92, Sacramento, CA 95825
(916) 263-2389 Fax (916) 263-2387 www.mbc.ca.gov

AGENDA ITEM 7D

Date: July 13, 2007

To: Members, Medical Board of California

From: Dave Thornton
Executive Director

Subject: Federation of State Medical Boards' Request to Distribute Book to All California Physicians and Surgeons

The Federation of State Medical Boards (FSMB) Research and Education Foundation, working with Scott Fishman, M.D. a pain management specialist and one of our Expert Reviewers, developed a book titled, *Responsible Opioid Prescribing, A Physician's Guide*. This book was developed "to further advance patient access to appropriate pain care and minimize risks of abuse and diversion." The FSMB hopes to eventually distribute this book to all physicians in the United States.

The FSMB is asking the MBC to agree to distribute this book to its in-state physicians (enclosed is a letter from James N. Thompson, M.D., FSMB President and Chief Executive Officer dated July 1, 2007). As Dr. Thompson explains, the MBC's commitment to participate in this project will assist the FSMB in securing the funding from various sources to provide this book to state medical boards and cover all costs of distribution to their licensees.

I request your approval to distribute this book to all current in-state licensees and new licensees, and to direct staff to work with FSMB to on the funding to cover the cost of distribution.

Attachments

Federation of
STATE
MEDICAL
BOARDS

RESEARCH & EDUCATION FOUNDATION

July 1, 2007

David Thornton
Executive Director
Medical Board of California
1426 Howe Ave., Ste. 54
Sacramento, CA 95825-3236

Dear Mr. Thornton:

The Federation of State Medical Boards Research and Education Foundation (the Foundation) has completed the first phase of a special project to educate physicians nationwide about safe and effective pain management practice and to relieve anxiety associated with prescribing opioids.

Over the past several years, state medical boards have adopted policy, rules or regulations reflecting the principles contained in the Federation of State Medical Boards *Model Policy for the Use of Controlled Substances for the Treatment of Pain (2004).* State pain policies have supported and contributed to improved quality and access to pain care in the U.S. The *Model Policy* represents concise consensus guidelines for safe opioid prescribing but, to date, has not been translated into practical terms for clinical practice. Accordingly, few physicians are familiar with these guidelines, and even fewer utilize them in their practice. To further advance patient access to appropriate pain care and minimize risks of abuse and diversion, the Foundation developed the book, *Responsible Opioid Prescribing, A Physician's Guide,* the first coordinated effort to translate pain policy into clinical practice. Distribution of the book to practicing physicians will significantly support efforts to alleviate confusion among physicians as to their respective obligations to patients in pain and to comply with state and federal regulations; and, address physicians' fear of regulatory scrutiny even when prescribing in appropriate settings, all contributing factors to the undertreatment of pain.

The Foundation initiated this physician education program to promote transparency and pharmacovigilance among physicians who prescribe opioids for pain management. The Foundation will work with individual state medical boards to distribute the book to their licensees. In that regard, the Foundation is securing funding support from a coalition of organizations, foundations, professional societies and industry to provide books to state medical boards for distribution to their licensees and cover all costs associated with such distribution.

On behalf of the Foundation, I hope that the Medical Board of California will support this project by agreeing to distribute the book to its in-state physicians. The Board's commitment to participate in this project will certainly facilitate and strengthen the ability of the Foundation to solicit and obtain funding.

Sincerely,

James N. Thompson

James N. Thompson, M.D.
FSMB President and Chief Executive Officer
Secretary, FSMB Research and Education Foundation

JNT/lar

Washington, D.C. 20537

JUN 15 2007

James N. Thompson, M.D.
President, Chief Executive Officer
Federation of State Medical Boards
P. O. Box 619850
Dallas, Texas 75261-9860

Dear Dr. Thompson:

This letter is in response to correspondence dated May 11, 2007 from Scott M. Fishman, M.D., to the Drug Enforcement Administration (DEA) requesting comment and support concerning the book *Responsible Opioid Prescribing* published by the Federation of State Medical Boards (FSMB). We understand the book is intended to be presented as a physician's guide to providing improved patient care while reducing the diversion of controlled substances used in the treatment of pain.

DEA commends efforts by the FSMB and other medical authorities to establish medical practice guidelines focusing on the proper prescribing of opioids. While opioids can be a vital component of legitimate treatment of pain, the abuse (nonmedical use) of such drugs is a serious and growing health problem in this country. Recent statistics published in the National Survey on Drug Use and Health demonstrate that prescription drugs account for the second most commonly abused category of drugs, behind marijuana and ahead of cocaine, heroin, methamphetamine, and other drugs.

As DEA stated in its September 6, 2006 Policy Statement: Dispensing Controlled Substances for the Treatment of Pain, our agency's role is to ensure that controlled substances are prescribed and dispensed for legitimate medical purposes by practitioners acting in the usual course of professional practice and otherwise in accordance with the Controlled Substances Act and DEA regulations. While it is certainly appropriate for physicians and medical oversight boards to explore the types of questions addressed in medical practice guides such as *Responsible Opioid Prescribing*, it would be beyond DEA's role to endorse such a guidance document. Nonetheless, DEA appreciates that the FSMB is seeking to promote critical discussions within the medical community on this subject and adherence to professional standards regarding the overall practice of medicine.

copy of this book.

Sincerely,

Joseph T. Rannazzisi
Deputy Assistant Administrator
Office of Diversion Control

State of California Department of Consumer Affairs

Medical Board of California

Agenda Item 10

July 16, 2007

TO: Members
Medical Board of California

FROM: Kimberly Kirchmeyer, Deputy Director

SUBJECT: Strategic Planning

Attached is the first draft for the Medical Board of California's new Strategic Plan. Upon completion of the strategic planning meeting in March, a document was put together that identified the objectives that were developed. Those objectives were split into "near term" objectives and "long term" objectives. Because there was an extensive list of long term objectives, members were requested to identify their top five objectives in order of priority. The voting was tallied and the top five priorities of the Board were identified as the long term objectives that will be implemented within the next three years.

At the meeting on July 26, 2007 Lewis Michaelson will facilitate the review of this draft Strategic Plan. Please review the document and be prepared to discuss it at the meeting. Specific input is requested on the individual workplans to ensure that staff is moving forward in the right direction.

MEDICAL BOARD OF CALIFORNIA

STRATEGIC PLAN 2007

Medical Board of California

Richard D. Fantozzi, M.D., President
Ronald L. Moy, M.D., Vice President
Laurie Gregg, M.D., Secretary
Steve Alexander
Cesar Aresteigueita, M.D.
James A. Bolton, Ph.D.
Hedy Chang
John Chin, M.D.
Stephen Corday, M.D.
Dorene Dominguez
Shelton Duruisseau, Ph.D.
Gary Gitnick, M.D.
Mitchel S. Karlan, M.D.
Reginald Low, M.D.
Mary Lynn Moran, M.D.
Janet Salomonson, M.D.
Gerrie Schipske, RN, NP, J.D.
Ronald H. Wender, M.D.
Frank V. Zerunyan, J.D.
Barbara Yaroslavsky

Dave Thornton, Executive Director

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Workplans ____ 13
Attachments:
    1) MBC Planning Retreat Summary
    2) Post Retreat Survey Results

INTRODUCTION

The Medical Board of California is legally mandated to make its first priority to protect the public. This mandate is articulated in Business & Professions Code Section 2001.1, which states:

> Protection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

While the mandated functions of the Board generally fall into two categories, licensing and discipline, there are other, more broadly defined issues relating to healthcare that impact the protection of the public.

Acknowledging that California's healthcare landscape is ever changing, that the current environment of healthcare delivery is under great strain, and that the business of medicine may contribute to preventing access to healthcare or promote substandard care, this plan addresses issues beyond the simple issuing of licenses and rendering of disciplinary actions. This plan builds upon the 2002 plan, augmenting its mission and addressing issues more broadly related to healthcare.

STRATEGIC PLANNING PROCESS

The Board appointed a two-person committee to shepherd the members through the planning process. Drs. Gary Gitnick and Ronald Moy worked with the staff and the facilitator throughout the process. Initially, members were polled for their opinion on the issues that should be of greatest priority to the Board. Facilitator, Lewis Michaelson, of Katz & Associates, compiled the members' initial opinions, which served as a blueprint for discussions at a two-day retreat where the essential priorities and initiatives were discussed. Following the retreat, members were surveyed on the essential long-term goals. The plan reflects the results of all of the discussions and surveys of the members.

THE PLAN

Mission:

In the Board's 1997 Strategic Plan, the members adopted the following mission statement:

> The mission of the Medical Board of California is to protect the public through proper licensing of physicians and surgeons and certain allied health professions and through the vigorous, objective enforcement of the Medical Practices Act.

This same mission statement was affirmed by the Medical Board in 2002. The current membership augmented the mission statement to address the promotion of healthcare, and adopted the following mission statement:

> The mission of the Medical Board of California is to protect healthcare consumers through proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practices Act, and, *to promote access to quality medical care through the Board's licensing and regulatory functions.*

This augmented mission statement demonstrates this Board's recognition that promoting quality care by high licensing standards and disciplining licensees only protects the public if they have access to healthcare.

Goals and Objectives:

The 2007 planning process focused on the practical, and established a number of objectives. These objectives were divided between "Near Term" and "Emerging" The Board affirmed the goals adopted in the previous plan, amending some slightly:

Professional Qualifications:
~~Ensure~~ *Promote* the professional qualifications of medical practitioners by setting requirements for education, experience and examinations, *taking into account the states needs for more physicians, particularly in underserved populations.*

Regulations and Enforcement:
Protect the public by ~~(1) preventing violations and (2)~~ effectively enforcing laws and standards when violations occur *in order to deter violations*.

Consumer Education:
Increase public awareness of MBC's mission, activities and services.

Organizational Relationships:
Improve effectiveness of relationships with related organizations to further MBC's mission and goals.

Organizational Effectiveness:
Enhance organizational effectiveness and systems to improve service to constituents.

Most of the objectives contained in this plan primarily relate to organizational effectiveness and professional qualifications. While the objective may fall mostly under these two categories, many also are relevant to relationships with organizations representing the various interests of those affected by Board actions. Public outreach programs have already been established and continue to be a major part of the Board's business, and need not be addressed by specific objectives in this plan.

Objectives that were established were specific. The majority of the near-term objectives are already in progress, and will eventually evolve into further objectives. Many of the objectives are studies or fact-finding in nature, which will give the members the information needed to establish future, more concrete objectives. For that reason, the measurements in many of the workplans contain only "completion" as the measure, without

periodic benchmarks. Regardless, the goal of all of the objectives is to establish a more efficient operation to protect patients and improve healthcare.

Near-Term Objectives:

At the two-day retreat in March, it was the consensus of the members that the following were the important near-term objectives:

- Implement the restructuring of the board to ensure greater communication and synergy between enforcement and licensing.
- Evaluate diversion program report and decide whether to sunset program or how to revise program.
- Manage selection and orientation of new executive director so that a smooth and seamless transition occurs.
- Coordination of Board relocation
- Finish report on new vertical enforcement model and take actions necessary to ensure its success.
- Take steps necessary to arrest and reverse loss of investigators; address imbalances that are contributing to investigator retention problem.
- Perform a complete audit of the Licensing Program
- Evaluation of peer review study and address the issues identified
- Complete a review of the public disclosure law and take actions necessary to address issues identified
- Implement creation of a Chief Medical Officer position
- Finish public disclosure laws review and take actions necessary to address issues identified.

Work on most of the above objectives is already in progress, to varying degrees. The Board's relocation and the hiring of an Executive Director are moving forward. The restructuring of the Board and the future of the Diversion Program are in the hands of the Legislature. A contract for the peer review study had been awarded. The creation of the Chief Medical Officer position is underway, and should be in place before the strategic plan is adopted. (For that reason, this will be noted in the "workplans" section as a "near-term" objective.)

As you can see from these objectives, the findings of the studies and review will give rise to more specific objectives, beyond the ability of this plan to address.

Emerging Objectives:

At the March Retreat, members stated the following were emerging trends or objectives that might be addressed by the Board:

- Develop a plan for addressing access to care and the shortage of doctors that is appropriate to MBC's mission and resources.
- Examine and develop recommendations on scope of practice and corporate practice issues to address concern that unlicensed and poorly supervised medical care is on the increase due to trends in where, by whom and how medicine is being practiced.
- Develop better ways of assessing MBC "customer satisfaction" and implement changes that would better serve applicants, licensees and the public.
- Develop measures and related data generation tools that will enhance feedback from enforcement to improve licensing and education.
- Develop a program to pro-actively address the medical errors issue.
- Examine current level and deployment of outreach resources and develop recommendations on enhanced efforts.
- Address MBC's role in regulating alternative medicine.
- Develop a program for enhanced legislative outreach and engagement.
- Examine current and alternative models for maintenance of certifications and develop recommendations.
- Examine current continuing education model and recommend changes that would better assure competency as the outcome.
- Examine the impact of electronic medical records (EMR) on the practice of medicine and develop recommendations to address quality of care and medical errors issues.

Acknowledging the Board's resources were limited, and that many of the above objectives overlapped with others, members were asked to select the ones they considered the top five priorities that should be addressed in the plan. The following were selected:

- Examine current continuing education model and recommend changes that would better assure competency as the outcome.
- Develop a plan for addressing access to care and the shortage of doctors that is appropriate to MBC's mission and resources.
- Examine and develop recommendations on scope of practice and corporate practice issues to address concern that unlicensed and poorly supervised medical care is on the increase due to trends in where, by whom and how medicine is being practiced. (As this objective is presently being addressed through the work mandated by B&P Code Section 2023.5 by the Medical and Nursing Boards, this objective will be placed in the "Near Term" objectives portion of the "action plans")
- Develop better ways of assessing MBC "customer satisfaction" and implement changes that would better serve applicants, licensees and the public.
- Develop a program to pro-actively address the medical errors issue.

The above objectives do not readily yield to specific performance measures. Many require the establishment of a fact-finding process before any work can begin to address the problem they are attempting to remedy. For that reason, workplans focus on the examination process. Once an examination or study is completed, performance measures and benchmarks may be established.

Goals, Relating Objectives, and Measures:

Goal 1: Professional Qualifications

Promote the professional qualifications of medical practitioners by setting requirements for education, experience and examinations, taking into account the state's need for more physicians, particularly in underserved populations.

Objectives that fall under this goal, and their performance measures:

- Examine current CME model and make recommendations to assure greater competency. (LT)*
  Measure: Completion of the examination and adoption of recommendations. (Also relates to Goal 4)
- Develop a plan for addressing access to care and the shortage of doctors that is appropriate to MBC's Mission and resources. (LT)
  Measure: Completion of the development of a plan to address healthcare access shortages. (Also relates to Goal 4)
- Develop a program to address medical errors. (LT)
  Measure: Completion of the development of a program. (Also relates to Goals 2 and 4)

Objectives also related to Goal 1:

- Evaluation of peer review study and address the issues identified. (NT)**
  Measure: Study is completed and recommendations are adopted. (Primary Goal 2, also relates to Goal 4)

* LT - Long Term, Emerging Objective
** NT - Near Term Objective (Complete within a year)

Goal 2: Regulation and Enforcement:
Protect the public by effectively enforcing laws and standards when violations occur in order to deter violations.

Objectives that fall under this goal, and their performance measures:

- Finish report on new vertical enforcement model and take actions necessary to ensure its success. (NT)
  Measure: Completion of report and implementation. (Also relates to Goal 5)
- Evaluation of peer review study and address the issues identified. (NT)
  Measure: Study is completed and recommendations are adopted. (Also relates to Goals 1 and 4)
- Examine and develop recommendations on scope of practice and corporate practice issues to address concern that unlicensed and poorly supervised medical care is on the increase due to trends in where, by whom and how medicine is being practiced. (NT)
  Measure: Completion of work to comply with B&P Code Section 2023.5 with the Nursing Board, recommendations are adopted and implemented. (Also relates to Goal 1 & 4)

Objectives also related to Goal 2:

- Develop a program to address medical errors. (LT)
- *Measure:* Completion of the development of a program. (Primary Goal 1, also relates to Goals 4 and 5)
- Take steps necessary to arrest and reverse loss of investigators; address imbalances that are contributing to investigator retention problem. (NT)
  Measure: Parity of salary and workload is achieved. (Primary Goal 5)

Goal 3: **Consumer Education:**
Increase public awareness of MBC's mission, activities and services.

Objectives that fall under this goal and their performance measures:

- Complete a review of the public disclosure law and take actions necessary to address issues identified. (NT)
  Measure: Review of law completed, recommendations are adopted, and appropriate actions are taken. (Also relates to Goal 4)

Goal 4: **Organizational Relationships:**
Improve effectiveness of relationships with related organizations to further MBC's mission and goals.

While there were no objectives that primarily fell under the primary goal of Organizational Relationships, **Objectives** that **relate** to this goal and their performance measures:

- Develop better ways of assessing MBC "customer satisfaction" and implement changes that would better serve applicants, licensees and the public. (LT)
  Measure: Satisfaction of Board service is adequately assessed and changes as a result provide for improved customer satisfaction. (Primary Goal 5)
- Examine current CME model and make recommendations to assure greater competency. (LT)
  Measure: Completion of the examination and adoption of recommendations. (Primary Goal 5, also relates to Goal 1)
- Develop a plan for addressing access to care and the shortage of doctors that is appropriate to MBC's Mission and resources. (LT)
  Measure: Completion of the development of a plan to address healthcare access shortages. (Primary Goal 1)
- Develop a program to address medical errors. (LT)
  Measure: Completion of the development of a program. (Primary Goal 1, also relates to Goal 2)

- Examine and develop recommendations on scope of practice and corporate practice issues to address concern that unlicensed and poorly supervised medical care is on the increase due to trends in where, who and how medicine is being practiced. (NT)
  Measure: Completion of work to comply with B&P Code Section 2023.5 with the Nursing Board, recommendations are adopted and implemented. (Primary Goal 2, also relates to Goal 1)
- Complete a review of the public disclosure law and take actions necessary to address issues identified. (NT)
  Measure: Review of law completed, recommendations are adopted, and appropriate actions are taken. (Primary Goal 3)

Goal 5: Organizational Effectiveness:
Enhance organizational effectiveness and systems to improve service to constituents.

Objectives that fall under this goal and their performance measures:

- Develop better ways of assessing MBC "customer satisfaction" and implement changes that would better serve applicants, licensees and the public. (LT)
  Measure: Satisfaction of board service is adequately assessed and changes as a result provide for improved customer satisfaction. (Also related to Goal 4)
- Take steps necessary to arrest and reverse loss of investigators; address imbalances that are contributing to investigator retention problem. (NT)
  Measure: Parity of salary and workload is achieved. (Also relates to Goal 2)
- Evaluate Diversion Program report and decide whether to sunset program or how to revise program. (NT)
  Measure: Completion of work with Legislature. (Outcome is dependent upon legislative action, now in progress.)

- Implement the restructuring of the Board to ensure greater communication and synergy between enforcement and licensing. (NT)
  Measure: Implementation is completed. (Outcome is dependent upon legislative action, now in progress.)
- Perform a complete audit of the Licensing Program. (NT)
  Measure: Audit is completed, recommendations are adopted and implemented.
- Manage selection and orientation of new executive director so that a smooth and seamless transition occurs. (NT)
  Measure: New Executive Director is hired and fully oriented. (Selection is in process.)
- Coordination of Board Relocation. (NT)
  Measure: Headquarters is fully relocated and equipped. (In process)

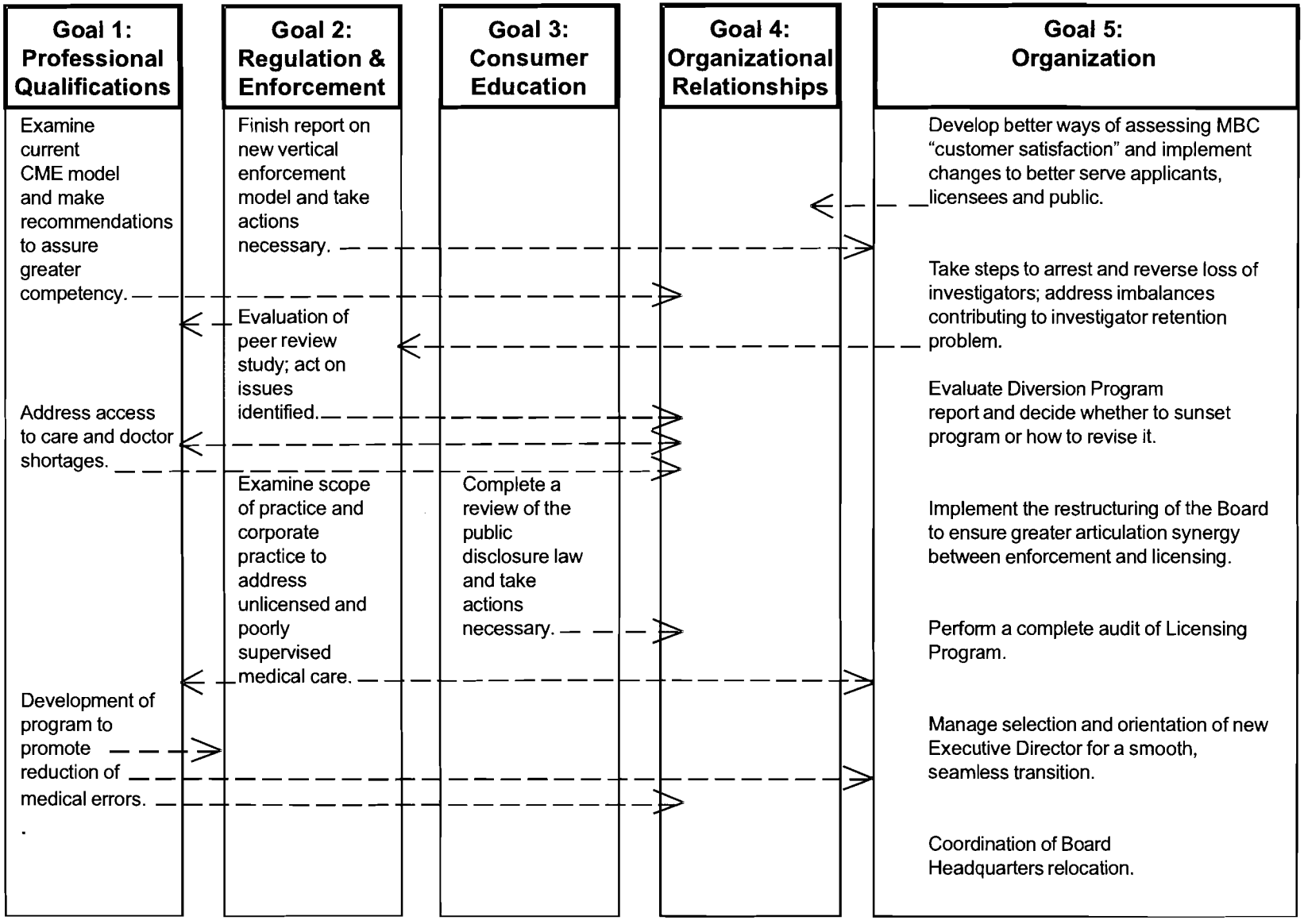
Objectives also related to Goal 5:

- Finish report on new vertical enforcement model and take actions necessary to ensure its success. (NT)
  Measure: Completion of report and implementation. (Primary Goal 2)

Conclusion

This plan represents the Board's understanding of the complex problems facing Californians in healthcare, and demonstrates the wisdom to know what it doesn't know. It focuses on fact-finding to determine the best answers to problems. As strategic plans should be living documents, able to adjust to the changing landscape, the Board will review the progress of the plan every quarter at its regularly held meetings, and plans and performance measures will be established and adjusted to the environment. This plan is not a final product, it is a statement of intention that will evolve with better knowledge and maturity.

INTER-RELATIONSHIPS OF GOALS AND OBJECTIVES:



Workplans:

Goal 1:	**Professional Qualifications** Promote the professional qualifications of medical practitioners by setting requirements for education, experience and examinations, taking into account the state's need for more physicians, particularly in underserved populations.		
OBJECTIVE:	**STAFF:**	**WORK:**	**DATES:**
Examine current CME model and make recommendations to assure greater competency. (LT - Also relates toGoal 4)	Medical Director	Work to begin after hiring and orientation of Medical Director.	Committee work will examine and develop potential strategies for increasing access to care, ultimately to make recommendations to the Board for possible legislative or regulatory action.
Develop a plan for addressing access to care and the shortage of doctors that is appropriate to MBC's Mission and resources. (LT - Also relates to Goal 4)	Medical Director to direct study, examination, and committee work.	Linda Whitney and Kevin Schunke to coordinate and staff committees, such as Telemedicine, Access to Care, and Scope of Practice.	Progress to be reported quarterly, and assessed annually.

Workplans:

Goal 1:	Professional Qualifications Promote the professional qualifications of medical practitioners by setting requirements for education, experience and examinations, taking into account the state's need for more physicians, particularly in underserved populations.		
OBJECTIVE:	**STAFF:**	**WORK:**	**DATES:**
Develop a program to address medical errors. (LT - Also relates to Goals 2 & 4)	Medical Board Committee Members Janie Cordray - Staffing for the Committee on Medical Errors.	Planning meeting. Establish schedule and agendas for committee meetings, including topics to be discussed. Committee meetings. Committee to make recommendations for policy, regulatory, or legislative changes, or participation in or establishment of error reduction initiatives or programs. Based on recommendations, legislation sought, regulations promulgated, or policy implemented. Based on recommendations, participation in error-reduction initiatives or programs.	June 2007 July 2007 August 2007 through July 2008 July 2008 July 2008 As appropriate.

Workplans:

Goal 2: Regulation and Enforcement:
Protect the public by effectively enforcing laws and standards when violations occur in order to deter violations.

OBJECTIVE:	STAFF:	WORK:	DATES:
Finish report on new vertical enforcement model and take actions necessary to ensure its success. (NT - Also relates to Goal 5)	Renee Threadgill	Report to be written and submitted to Department, Board, and Legislature Implement recommendations and proposed changes or legislation, as appropriate	June 27, 2007 Determined by Board or Legislative Action

Workplans:

Goal 2: Regulation and Enforcement:
Protect the public by effectively enforcing laws and standards when violations occur in order to deter violations.

OBJECTIVE:	STAFF:	WORK:	DATES:
Evaluation of peer review study and address the issues identified. (NT - Also relates to Goals 1 & 4)	Kimberly Kirchmeyer - coordination and oversight of contract. Lumetra, contractor. Linda Whitney- Legislative or regulatory work, if required.	Award contract Contract signed Study performed Draft Report submitted to staff Final report submitted to Board Report submitted to Legislature Regulations promulgated, if needed Legislation sought, if needed Implementation of new legislation or regulations	June 2007 July 2007 August 2007- March 2008 April 2008 May 2008 July 2008 November 2008 January 1, 2009 January 1, 2010

Workplans:

Goal 2: Regulation and Enforcement:
Protect the public by effectively enforcing laws and standards when violations occur in order to deter violations.

OBJECTIVE:	STAFF:	WORK:	DATES:
Examine and develop recommendations on scope of practice and corporate practice issues to address concern that unlicensed and poorly supervised medical care is on the increase due to trends in where, by whom and how medicine is being practiced. (NT - Also relates to Goals 1 & 4)	Janie Cordray - coordination and development of B&P Code Section 2023.5 project in consultation with the Board of Registered Nursing	<u>B&P Code Section 2023.5 Project:</u> Coordinate public meetings with Nursing Board and interested parties.	July '07
		Estabish Agendas and hold, at minimum, three meetings.	August through October '07
		Write draft report, including recommendations, for submission to Nursing and Medical Boards	November '07 to January '08, as appropriate.
		Adoption of report and recommendations	February '08
		Sumbit report to Legislature	March '08
		Seek legislation or promulgate regulations, as needed.	As legislative and regulatory calendar allows.
	Renee Threadgill, Enforcement, Operation Safe Medicine	<u>Operation Safe Medicine:</u> Re-establish and staff Operation Safe Medicine.	Re-establishment already in process. In full operation by October '08

Workplans:

Goal 3: Consumer Education:
Increase public awareness of MBC's mission, activities and services.

Objective:	Staff:	Work:	Dates:
Complete a review of the public disclosure law and take actions necessary to address issues identified. (NT - Also relates to Goal 4)	California Research Bureau (per B&P Code Section 2026) Enforcement, IT Staff to assist CRB in providing data and information. Linda Whitney and Legislative/ Regulatory Staff to initiate the promulgating of regulations	CRB to conduct study and write report, including policy options. Recommendations adopted, if appropriate. Regulations promulgated, if necessary Legislation sought, if needed.	August '07 - March '08 May '08 or July '08 November 2008 January '09

Workplans:

Goal 5: Organizational Effectiveness:
Enhance organizational effectiveness and systems to improve service to constituents.

OBJECTIVE:	STAFF:	WORK:	DATES:
Develop better ways of assessing MBC "customer satisfaction" and implement changes that would better serve applicants, licensees and the public. (LT- Also relates to Goal 4)	Licensing staff, Cashiering staff, Enforcement staff (depending upon program to be assessed), to be determined. Coordinated by Candis Cohen.	Development of method of assessment to be determined. It is likely that the following will be needed; Research companies and cost to develop survey instruments Hire Consultant. Development of a survey instrument, perform sampling. Development of an assessment program. Examination of program results. Development and adoption of recommendations. Changes initiated and implemented.	To be determined.

Workplans:

Goal 5: Organizational Effectiveness:
Enhance organizational effectiveness and systems to improve service to constituents.

Objective:	Staff:	Work:	Dates:
Take steps necessary to arrest and reverse loss of investigators; address imbalances that are contributing to investigator retention problem. (NT - Also relates to Goal 2)	Renee Threadgill, Enforcement Jill Johnson, Human Resources	Waiting for determination on Vertical Enforcment legislation or Board action. Work with DPA on establishing Pay Differential to reflect parity with other agencies.	July '07 Meeting: Begin process of Vertical Prosecution determination. January '08 - If investigators are not moved to Department of Justice, work begins with DPA.
Evaluate Diversion Program report and decide whether to sunset program or how to revise program. (NT)	Frank Valine, Staff Members, Diversion Committee	Completion of Report Development and adoption of recommendations or proposed changes to the program, based on report or legislation. Development of evaluation measures for recommendations or changes adopted. (Staff) Ongoing oversight, based on evaluation measures.	June 7, 2007 December 31, 2007 July '07 Meeting Begins July meeting '07, and is ongoing.

Workplans:

Goal 5: Organizational Effectiveness:
Enhance organizational effectiveness and systems to improve service to constituents.

Objective:	Staff:	Work:	Dates:
Implement the restructuring of the board to ensure greater communication and synergy between enforcement and licensing. (NT)	Lead Coordiation: Kimberly Kirchmeyer Gary Qualset, Licensing Renee Threadgill, Enforcement	Make assignments to Committees of Licensing and Enforcement . (Board president will make assignments, Ms. Kirchmeyer to coordiate activities.) Training of members in Divisions' work (Division Chiefs) Development of manual for committee members (Division staff, coordination by Chiefs) Changing procedures to re-design	November '07 November '07 February 1, 2008 February 1, 2008

Workplans:

Goal 5: Organizational Effectiveness:
Enhance organizational effectiveness and systems to improve service to constituents.

OBJECTIVE:	STAFF:	WORK:	DATES:
Perform a complete audit of the Licensing Program. (NT)	Gary Qualset, responsible for coordination of licensing staff participation in audit. Kimberly Kirchmeyer, responsible for selecting personnel to conduct audit and oversight of audit and report.	Select personnel or contractor to conduct audit --- including drafting RFP, selection process, and contract. Audit plans developed and submitted for approval. Audit conducted. Audit report written, including recommendations, and submitted to Executive Director. Report submitted to Board, recommendations adopted, if appropriate. Changes to program allowed without legislation implemented, including promulgation of regulations. Legislation sought, if needed.	January '08, contract signed January-March '08, Audit conducted. June'08 July '08, August '08 January '09

Workplans:

Goal 5: Organizational Effectiveness:
Enhance organizational effectiveness and systems to improve service to constituents.

OBJECTIVE:	STAFF:	WORK:	DATES:
Manage selection and orientation of new executive director so that a mooth and seamless transition occurs. (NT)	Board President, in consultation with Executive Committee, Selection Management; Kimberly Kirchmeyer and Division	President/Vice President to meet with Executive Director Deputies to present status report of all programs and any urgent topics needing attention or of interest.	Within 30 days of appointment. Within one week of appointment.
Coordination of Board Relocation. (NT)	Teri Hunley - facilities and equipment. Diane Ingram - IT Coordination Kimberly Kirchmeyer - staff coordination and placement.	Lease Agreement (Done.) Moving and IT Contracts (Done.) Coordination of move and staff placement.	Dates yet to be determined. Completed by December 31, 2007

Medical Board of California Strategic Planning Retreat Notes
March 1-2, 2007

I. Overview of Board Member Survey Results

To lead off the strategic planning retreat, the facilitator, Lewis Michaelson, summarized the results of responses he received from a board member survey conducted prior to the meeting. The response were organized into the following four categories:

Challenges
- Continuously improving licensing and enforcement
- Increased public scrutiny
- Maintaining staff, particularly investigators
- Keeping pace with medical technology
- Health care reform

Goals
- Improve licensing and enforcement programs
- Better engage constituents
- Be a model for other boards

Areas for Improvement
- Board effectiveness
- Greater public visibility and communication
- More proactive approach to physician wellness
- Access to care

Retreat Objectives
- Establish and prioritize goals
- Provide direction to MBC staff on programs and policies

II. Critical Review of Current Programs/Performance

While citing the somewhat "chicken-and-egg" nature of where to start the strategic planning discussion, the board agreed to stick with the proposed agenda's first topic of gathering feed-back from board members on how they would assess the MBC's current performance among its various programs and initiatives. The discussion focused on the following topics:

Licensing
- Enforcement monitor gave us big window on our performance; a similar audit on licensing is needed
- How can we expedite the licensing process?

ATTACHMENT # 1

- We haven't done an assessment for licensing at the same level as enforcement
- The time to begin an application review has been shortened by 50 percent
- Have we asked the applicants themselves about their perception of our performance as a potential measure of our success?
- There is a tension between Quantity vs. Quality; speeding things up can't come at the cost of doing a good job of screening applicants well
- Should we consider more probationary licenses?
- We have to maintain our effectiveness at weeding out bad applicants
- We should analyze obstacles to licensing for efficiency/effectiveness
- We should emphasize more customer-friendly outreach to potential applicants
- Need more crosstalk between licensing and enforcement – licensing could learn from enforcement experience
- Early outreach to potential applicants and onsite registration has been effective
- We have only one FTE for licensees to call in for information; is that really enough to be more customer-oriented?
- Much of the licensing process is dictated by law/regulations, so there are limits to what we can retool in the process
- Speed can't come at the expense of quality
- Survey of "customers" is needed

Re-licensing

- We need to look at how we can partner with specialty boards
- What should our policies be on various types of C.E. (e.g., online)?
- Can we demonstrate relevance/effectiveness of C.E.?
- C.E. must reflect competency
- Are C.E. requirements counter-productive? Some studies show there is more professional learning undertaken when people are left to do it voluntarily
- Need to look at continuous re-certification – M.O.C.

Enforcement/Discipline

- We are working through a new enforcement model, including shortened time frames for processing
- We are waiting for enforcement report in April to tell us more about our performance
- Can we use enforcement data to inform licensing/education?
- Can we spot discipline trends and adjust education to prevent them?
- Are medical documentation requirements unrealistic?
- Even if documentation requirements are unrealistic, they will still be part of "charges" in disciplinary actions, because they are easier to prove
- How can we intervene and offer programs before transgressions begin?
- How can we do better outreach on availability of CMB support programs for physicians?
- There are not enough trained investigators and retention is reaching a crisis
- There have been great strides in expanding expert pool but need to expand further (a lot!)

Diversion

- New staff and focus have addressed many issues with previous program
- Don't know really if it's working – hopefully audit report will enlighten
- Should physicians have to pay?
- Diversion needs more attention than it has gotten so far
- If we ended it, something would need to replace it
- Half of people in program self-refer
- Diversion program addresses care and nurturing of physicians – it's humanistic
- Needs to be accountable
- Diversion is proactive
- Diversion is part of a wellness approach for doctors

Public Comment (Julie Fellmeth):

- Diversion audit will speak to long-standing, well-known issues
- No one knows if program is effective
- Biggest shortcoming is there is no post-program monitoring

Diversion - Board response:

- Are we going to treat substance abuse impairment same as other impairments?
- We need to treat this like other diseases
- Public perception may cause us to treat it differently
- There may be appropriate reasons to why we don't we monitor after program completion

Diversion (continued Board discussion)

- Not sure how feasible and at what cost post-monitoring should take place
- Want data on how many successfully complete program
- Wellness and diversion aren't often connected programmatically
- Legislative extension should incorporate means for follow-up
- Real question is should MBC have program at all?
- Given mission to protect public – is diversion our responsibility?
- What is appropriate end point for monitoring – 2 years is norm for chemical dependency; lifetime monitoring is an extraordinary standard
- Lengthening monitoring will discourage self-referral
- What would happen to discipline options if there were no diversion?
- We need to know what happens – do they remain doctors into the future?

Staffing

- Strategic plan for Executive Director transition is critical
- Retention issue must be addressed in strategic plan – Board should give policy direction but leave to management how to resolve

Outreach

- We're not reaching all our key constituencies
- Is positive public perception/reputation of MBC our goal?
- We have limited resources for outreach
- Are we being strategic in engaging our key constituents and leveraging our meetings/ presence?
- We need better customer service for our stakeholders – public and licensees
- Customer service needs greater emphasis and better access for them to MBC
- Not everyone will be satisfied
- Do we need to devote more resources to outreach?
- Need to be clear on ultimate goal
- Legislators are very key "constituents"
- We only have one legislative liaison
- Applicant outreach has been effective and could be ramped up

III. Core Constituencies

The next discussion focused on whom the Board considers its core constituencies, both in terms of whom the MBC serves and who influences the work of the MBC. The board offered the following list of key constituents:

- Consumers of healthcare, both in terms of where to go to make a complaint and how to check on doctors prior to using their services
- Underserved, who need improvement in consumer awareness
- Decision-makers
- Reporting agencies
- Elected officials
- Staff of elected officials
- Donors to elected officials
- Other law enforcement/investigators
- Licensees and applicants
- Medical schools/educators

IV. Emerging Trends/Issues/Challenges

Members were asked to identify the trends/issues/challenges they believed were affecting the medical field and the MBC's ability to meet its mission. They were then asked to identify the most urgent and/or critical ones to address in the strategic plan. The first10 bullets comprise the list of most urgent/critical.

- **Addressing medical errors**
- **Broadening scope of practice**
    - **MDs supervising more people**
- **Electronic Medical Records – and related falsification issues**

- **Ability to deliver health care effectively with trend toward using E.R. rather than doctor's office**
- **Delivery of healthcare through non-conventional means**
- **CME – how to make continuing education meaningful**
- **Maintenance of certification – similar to what specialty boards do**
- **Increasing trend in number of foreign-trained licensees**
- **Increased use of physician extenders – and their expanded scopes of practice**
- **Consider legislative liaison committee within Board**

Other Trends/Issues/Challenges

- Medi-spas
- Unlicensed corporate practice of medicine – cosmetic procedures
- Healthcare reform
- Telemedicine – outside of California
- Whole electronic medical records (EMR) issue
- Diversity of population
- Patients seeking on-demand healthcare
- Medical errors due to EMR
- Recertification – ACGME testing
- Non-evidence based practice of medicine
    - Alternative medicine
- Public's need to know an MD's board certification
- Ability to share information – shared medical records between facilities – EMR
- Addiction to prescription drugs, particularly via Internet usage
- Physician extenders expanded usage of the Medical Practice Act
- Distance learning
- International medical schools – work with them to help them provide quality education
- Recruitment of MDs to practice in California

V. Mission/Vision Discussion/Validation

Board members were then asked to discuss and validate the MBC's current vision and mission. In so doing, they were asked to consider the following criteria:

- Things we can do or do well
- Things we ought to do
- Things only we do
- Things others do as well as we
- Things that won't get done unless we do them

After examining the vision and mission in light of how emerging trends and challenges will impact the MBC, Board members agreed that the current mission reflected statutory mission, but is incomplete and out of step with reality, requiring an added element:

- Promote access to quality medical care through the Board's licensing and regulatory functions

The Board members agreed to use this working draft of additional mission language for purposes of subsequent retreat discussions, but indicated that further examination of the implications of this potential addition to the MBC's mission would have to be performed during the development of the strategic plan, e.g., what legislative action would be required to implement. However, given the current environment of serious and substantial discussions at high levels within the state about health care reform and more universal access to care, Board members agreed that it was highly likely that there would be an expectation placed on the MBC to at least be a part of the solution and that their mission should reflect this.

VI. Goals Discussion

Board members were asked to review current goals and suggest which ones should be carried over from the 2002 strategic plan and what new goals were needed in light of the previous day's performance review and today's assessment of critical trends and challenges. It was suggested that at the "goals" level, the previous strategic plan's five categories of goals were still appropriate. Possible additions to the breadth/scope of the 2002 goal statements included:

- Promote licensing of additional doctors
- Serve the under-served
- The members agreed to add the following language to the Professional Qualifications goal: "taking into account the state's needs for more physicians, particularly in under-served populations"

Related to the expanded mission statement, the group discussed possible objectives or measures for enhanced access to care, including:

- Expansion of international special training programs
- Increased outreach to other educational facilities
- Expansion of recognized international schools
- Scholarship program/loan repay
- Successful completion of 1095 program
- Educational tools to facilitate relationship between doctors and physician assistants
- Increased numbers of licensees
- Track percent of patients served by E.R. vs. primary care
- Distribution of physicians by geography

Board members were then asked to look at each of the five goal categories and identify key objectives for the new strategic plan:

Organizational Effectiveness

- Retention
    - Investigator
    - Staff
    - Support

- Transition to new Executive Director
- Develop better effectiveness indicators
- Implementation of new board structure – including committee structure
- Better performance monitoring and evaluation

Professional Qualifications

- Review of CME and its requirements – re-certification (see 6th and 7th bullets under IV)
- Need audit/monitoring program similar to enforcement (need more board input on information it wants)
- Reporting system for board on licensing performance
- Reporting system or fate of licensees in enforcement
- Customer service/satisfaction

Regulation/Enforcement

- Retention of investigators
- Performance measures for new prosecution model
- Address new issues raised by audit
- Should diversion be continued? Evaluate in light of sunset
- Long-term monitoring of interventions/remediation
- Expansion of expert pool and better training
- Should we engage in the "medical errors" issue?
- Other emerging enforcement trends, e.g., falsifications of records, etc.

Consumer Education

- Address changing demographics of consumer base, e.g., vulnerable populations
- Improve consistency and usefulness of information under public disclosure requirements
- Re-examine resources for consumer outreach
- Address regulations on what comes off Web site

Organizational Relationships

- Maintain/improve relationships with elected officials
- CMA/CPIL – maintain key relations/communication
- Explore stronger relationship with DHS and other state agencies, particularly related to access
- Explore relationships with medical specialties for continued competency

Public Comment

- The near term issues that will need to be addressed are already programmed for MBC:
    - Diversion Audit
    - Vertical Enforcement
    - Peer review
    - Public Disclosure Laws Review

VII. "Above/Below the Line"

Board members were asked to consider the resources of the organization and provide feedback on what objectives were essential and which ones might be laudable but beyond the MBC's capacity

- Increase call-in response capability
- Address continuing competency
- Develop a plan for dealing with access to care from MBC's perspective
- We need an operational strategy
- We have to address scope of practice issues and also corporate practice issues
- PSAs to get out our message and contact numbers
- Do we need to do specialty board evaluations?
- Should we be doing opticians' registration?
- Should we certify foreign schools – maybe create regional certification boards?

Members were asked to identify the primary mission/mandate/legislative programs and objectives that they perceived would consume the vast majority of the organization's "bandwidth" in the near-term:

- Diversion Program
- Restructuring
- Selection/transition of Executive Director
- Peer Review
- New Prosecution Model
- Retention Issue
- CMO creation
- Customer service
    - Conduct survey
- Outreach
- Licensing Audit
- Periodic Licensing Report
- Access to care

VIII. Next Steps

In the next phase of the strategic plan's development, staff was directed to suggest what criteria should guide the setting of priorities. They were also asked to assimilate and synthesize the board input from the retreat and present a strawman proposal to the board of near-term (less than one year) and emerging (1-3 years) objectives/initiatives in a format that would allow board members to be polled on priorities for the "emerging" time frame.

Post Retreat Survey Results:

Objectives:	Rank by total points*	Rank by "top 5" votes	Total points*	Total in "top 5"	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6	Member 7	Member 8	Member 9	Member 10	Member 11	Member 12	Member 13	Member 14	Member 15	Member 16	Member 17	Member 18	Member 19
Develop a plan for addressing access to care and the shortage of doctors that is appropriate to MBC's Mission and resources.	2	2	29	9				5	4	2	x	x	1	x	x	x	2	3		2		5	1
Examine and develop recommendations on scope of practice and corporate practice issues to address concern that unlicensed and poorly supervised medical care is on the increase due to trends in where, who and how medicine is being practiced.	1	4	30	7		1		2	2		x	x	3	x	x	x	1	2				1	
Develop better ways of assessing MBC "customer satisfaction" and implement changes that would better serve applicants, licensees and the public.	3	4	25	7	1		1				x	x	5	x	x	x			1	3	5		
Develop measures and related data generation tools that will enhance feedback from enforcement to improve licensing and education	5	5	21	6		5	2	1	4	1	x	x		x	x	x			2				
Develop a program to pro-actively address the medical errors issue.	4	3	23	8					5	3	x	x	4	x	x	x			3	1	2	4	3
Examine current level and deployment of outreach resources and develop recommendations on enhanced efforts.	9	7	5	2	3		4				x	x		x	x	x							
Address MBC's role in regulating alternative medicine.	10	8	1	1							x	x		x	x	x	5						
Develop a program for enhanced legislative outreach and engagement.	6	5	18	6	2	4	3				x	x		x	x	x		4			4		1
Examine current and alternative models for maintenance of certifications and develop recommendations.	8	6	10	5			5				x	x		x	x	x			5		3	3	4
Examine current continuing education model and recommend changes that would better assure competency as the outcome.	1	1	30	10	4	3		4	3	4	x	x		x	x	x	3		4		1	2	2
Examine the impact of electronic medical records (EMR) on the practice of medicine and develop recommendations to address quality of care and medical errors issues.	7	4	16	7	5	2		3		5	x	x	2	x	x	x	4	5					

* Points based on members' vote by ranking: Rank 1 = 5 points Rank 2 = 4 points Rank 3 = 3 points Rank 4 = 2 points Rank 5 = 1 point

ATTACHMENT # 2